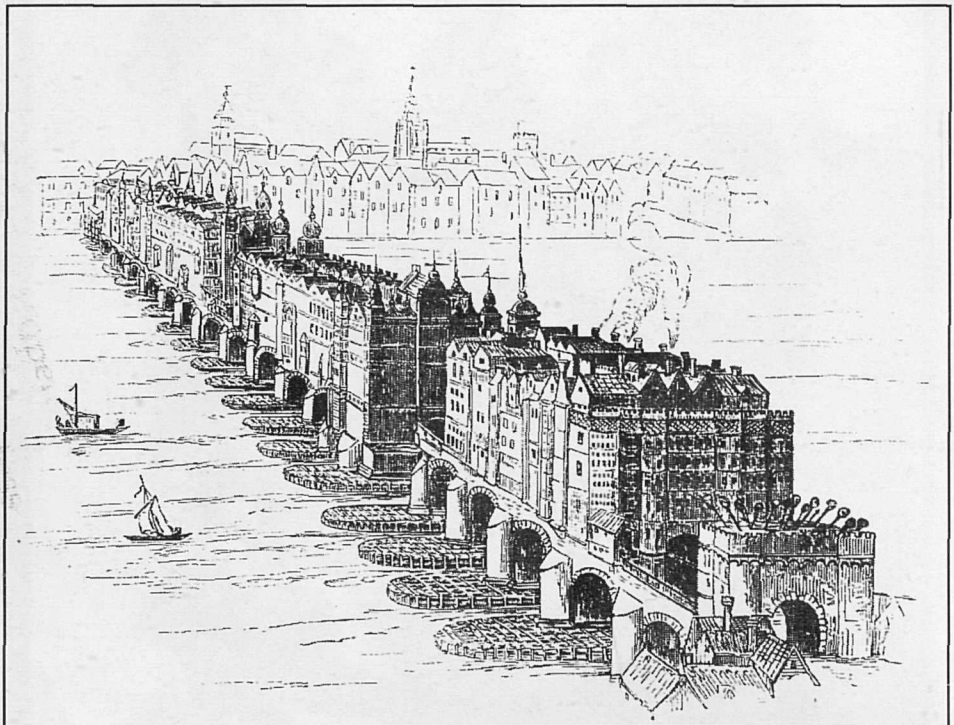
GUY'S

HOSPITAL GAZETTE

January 1996

- Elective Reports
- Dare Quam Accipere
- Interview with Professor Brookes



London Bridge, about 1616.

CONTENTS

2 **Passim**
4 **Letters**—Dental Ball, Security
8 **News**—Knighthood, ECMO
10 **Feature**—Elective Report
18 **Feature**—Dare Quam Accipere
25 **Feature**—Interview with Professor Brookes
29 **Reviews**—Medilinks, Study Disks
33 **Nursing Notes**—Then as Now, Nurses League
36 **Obituaries**—Annette McGowan, Dudley Grasby
40 **Sport**—Rugby, Boat Club, Football
47 **Classifieds and Announcements**

Guy's Gazette

Editor Rikin Trivedi **Assistant Editor** Paul Hayden **Sub Editor** Sue Ferguson **Features Editor** Kate Mundray **Sports Editor** John Davies **Nursing Notes** Denis Cobell **Office Manager** Margaret Flanders. **Acknowledgement** Dean Flanders.

The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

Volume 110 Number 2453 January 1996
ISSN 0017–5870

Guy's Gazette, Boland House, Guy's Hospital, London SE1 9RT. Tel (0171) 955 5000 ext 5413.
 All rights reserved.

Printed by Hobbs the Printers Ltd, Brunel Road, Totton, Hampshire SO40 3YS

PASSIM

We start this year by wishing all of our readers the warmest of greetings for the new year and we hope that prosper and good fortune is beset up on all.

The fresh new years chill has brought with it fresh new challenges that we must endure. We have heard much of the proposed merger between UMDS and the larger King's College, and as the parliamentary bill proceeds its long and arduous course, it is becoming more and more of a realisation. We all have reservations about this enactment, and concerns regarding identity, survival and representation seem to be common amongst the students, both past and present.

The administration at the medical school have put much thought into this merger and assure us that UMDS will only gain from this marriage. Support for this engagement has been forthcoming due to the benefits involved. In outline these include extensive redevelopment of the buildings around the memorial park on the Guy's site and the establishment of a multi-disciplined facility which will offer more variety in student integration.

However, the fact still remains that, we are offered little hope in securing our identity. It would appear that the days of UMDS students being honoured at Southwark Cathedral are numbered. Following the merger, all UMDS students are destined to be graduates of an, as yet, unnamed medical faculty of King's College. For those of you unfamiliar with the latter, I believe it is located somewhere on The Strand!

Our name is something that we are proud of at Guy's and I'm sure that the question of identity will be playing in the minds of many individuals. But is it time for us to finally to swallow our pride? Is it too late to air our grievances? From what we have learnt about the battle to save our hospital, we should never give up trying

Guy's Hospital Gazette

English Pewter 1 pt Tankards, Engraved with the Guy's Crest, available only from the *Gazette*, individually boxed.

Price £22+£1p&p

ORDER FORM

Name .....

Address .....

.....

Please send me . . . . . Guy's Tankards at £22+£1 p&p

I enclose a remittance of £.....

To: The Manager, Guy's Gazette Office,
Guy's Hospital, London SE1 9RT
Tel: 0171 955 5000 ext 5413
Personal Callers Welcome

Office hours: Monday to Friday 1–5 p.m.

Complacency?

I was sorry to read that Dr Horner feels that I am complacent concerning the future of Guy's Hospital. I am not.

The questions I was asked in the interview which was reported in the Gazette mainly concerned the Medical and Dental Schools and I am confident about their future but not complacent either. The future successes of our schools depends in no small measure on the future of Guy's Hospital. The new School of Biomedical Sciences, which will support the preclinical studies for both dentistry and medicine, will be located on the Guy's site, but without a thriving hospital, much of what we wish to achieve in both education and research would not be possible. The plans for the school in no way impinge on the hospital as the redevelopments will be restricted to the buildings around the park, so there is no conflict of interest between the hospital and school.

On a personal note, I have been associated with Guy's for most of my adult life, including the last twenty-three years on the staff of the hospital. The uncertainty about the future of Guy's is as painful to me as to anyone. I happen to believe, however, that there is a need for both Guy's, St Thomas' and indeed King's College Hospital, to continue on their present sites and that sensible rationalisation of clinical services should enable all three to prosper to the benefit of patients and of teaching and research. Not surprisingly, I regard Guy's as the most famous hospital in the world and I will certainly continue to do everything I can to ensure its future.

Yours faithfully,

C Chantler
Principal, UMDS

Dental Ball

Dear Sir,

As a (fairly old) Guy's graduate who has been bringing a party to the Dental Society Ball for a number of years I thought I should write and tell you how disappointed we were with this year's Ball.

I feel the main problem was the venue. There was not nearly as much room as there was at the Grosvenor, which had far more style, and the food was poor. Possibly because of the fact that the venue was most crowded, maybe because people's attitudes are changing or perhaps I am just getting old, but it seemed that there was far more pushing and shoving on the dance floor and bad manners, particularly smoking and drinking on the dance floor.

Yours faithfully,

Michael Dods

UMDS Security

Dear Sir,

I should be grateful to use your columns to reply to Mr A William's letter entitled 'Insecurity' published in the last issue of the Gazette.

My response focuses on two areas: first, my concern at the unfairness of the comments about our security staff; and secondly, the positive steps that we are taking to improve security, developments which must surely be evident to all.

Many collegues have commented in the weeks since the publication of Mr William's letter that our security staff are both courteous and helpful and have high professional standards. If anyone at any time has a different experience, the matter should, of course, be reported; there are no examples of critical reports to date.

I also wish to emphasise that there have been numerous occasions in the past period when our security staff have acted with great courage and indeed put their personal safety at risk in their role to make our campuses safer places for us all. It is surely incumbent on us to co-operate with them and support them in every way we can in this difficult task.

Having said this, we are very aware of the need to make our security arrangements more effective.

Our 'out-of-hours' control measures for the Medical School building have reduced crime by 80%. Intruder alarms have been installed on dental floors in the Tower. Patrols of the bicycle shed have been stepped up and incidentally, free bicycle security marking is available. Boland House now has 24-hour seven days-a-week security cover. More generally, card access to buildings is being progressively introduced and this will greatly help with unauthorised access to our buildings. Finally, the Management Board of UMDS will be looking at its February meeting at proposals for a closed-circuit television system.

Finally, I have to say that although we can do a geat deal, everyone has to be involved in making our buildings more secure.

Yours faithfully,

H T Musselwhite
Secretary, UMDS

Friendly Support

RE: The Friends of Guy's and of St Thomas' Hospitals

Dear Sir
The Friends depend not only on our members for support but rely on volunteers for many essential activities, such as the running of the Friends' shops, servicing the Trolley Shops for the wards, helping with flower arrangements and taking part in the Fetes and other fundraising activities.

We need more volunteers. Apart from the general public, we would particularly welcome friends and relatives of members of the staff. Please encourage them to join us. They would find it an enjoyable and rewarding experience. For Guy's:- contact the Friends' Office at Henriette Raphael House. Telephone Number: 0171 407-1058 or extension 5460. Secretary:- PatThe Friends of Guy's and of St Thomas' Hospitals. Hutton. For St Thomas':- contact the Friends' Office. Telephone number; 0171 928-9292 extension 2715 or 3595.
Yours faithfully,

G Scott & S Bateman

Freshers' Week

Dear Sir,
I read with sadness and disbelief the account of the Freshers Week 1995, with its emphasis and relish on the consumption of alcohol.

One line of the report typified the celebrations:'A night of sheer debauchery by one and all that would certainly make our ancestors turn in their graves, as people lost all sense of responsibility for a few hours.'

What a shameful start for young men and women embarking on their noble professional career at Guys.

I am not a tee-totaller!
Yours faithfully,

Gordon Lyle

Letters

We would like to hear your views on any issues raised in any of the Gazettes, or anything to do with Guy's. You may have an opinion you would like to share with the rest of the readership. We would like to see some of your points published in future issues. If you feel you want to air your thoughts please write to the editor.

You are reminded that it is at the editor's discretion whether to publish a letter and that derogatory personal references to any individual will not be acceptable. We will however do our best to let you have a say.

Annual Dinner

The 40th Annual Dinner of the Bournemouth and Wessex Guy's Hospital Society was held on Friday November 3rd at the Durlston Court Hotel, Bournemouth.

At the AGM, Dr I W Broomhead was elected chairman, Mr E Archard, Honorary Secretary, and Dr M O'Driscoll was made Honorary Treasurer. After the dinner, the guest of honour, Mr D Haskell, gave an account of events at Guy's during the last year.

ECMO

Once again the Paediatric Intensive Care Unit at Guy's Hospital was in the news over the festive period.

A pioneering new method of treatment was employed by the clinicians as a last ditch effort to save a young child from death due to menigococcal septicaemia. The procedure, extra-corporeal membranous oxygenation was on trial for the first time in an attempt to clear the child's blood of the bacteria, and hence relieve symptoms. The outcome was uncertain, but thankfully the young child who was given a fifty percent chance of survial showed early signs of recovery and is said to be well since.

Rolling Stones

The Trust's Stone Centre, which pioneered non-invasive treatment of kidney stones, recently celebrated its 10th anniversary.

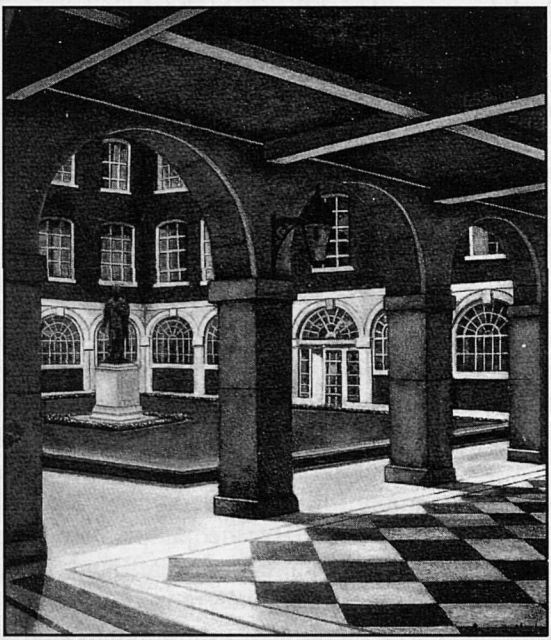
The party was attended by Health Minister Gerald Malone, former Health Secretary Virginia Bottomley, and former Trust chairman, Lord Hayhoe. Lithotripsy uses shockwaves to break down kidney stones which can then be excreted naturally. Prior to the introduction of lithotripsy, treatment involved relatively major surgery and in the last 10 years that the unit has been open, 14,000 patients have been treated.

Call me Sir!

In the New Year's Honours list, three members of staff at UMDS were honoured by Her Majesty the Queen. UMDS Principal, Professor Cyril Chantler, was awarded a Knighthood for his services to medicine. The Newland Pedley Professor of Oral Health Services Research, David Gibbons, was awarded an OBE for his services to community medicine in Kent and Sir Richard Doll, an honorary fellow of UMDS, has been made Companion of Honour.

Guy's Hospital
MEMORABILIA

Unique items available only from the Gazette



These high quality cards depicting the Colonnade are left blank inside for your own message. The original oil painting by Clare Walford, a recent graduate, was presented to Dr Scott in appreciation of his 20 years as Gazette Committee Chairman. Cards are available in packs of 10.

Price £10 per pack of 10 + £1 p&p

To: The Manager
Guy's Hospital Gazette
Boland House
St Thomas' Street
London SE1 9RT

I enclose a cheque/PO for £ .....
NAME: .....
ADDRESS: .....
.....
.....

Please make cheques payable to Guy's Hospital Gazette

Office hours: Monday to Friday 1-5 pm. Personal callers welcome.

Elective Report I:

Bloody Holidays and Dash Hortals

The first month of my elective was spent in Bangladesh. This is a relatively new country being formed from the then East Pakistan in 1971 after the Independence War. The country has been through a lot and I wanted to visit it both for personal reasons and to get another perspective of medical practice. The personal reason was that this is the birth place of my parents and although I was not born there I still feel a strong sense of belonging to it.

The country is the largest delta in the world and as such is subjected to yearly floods which add considerably to mortality figures. A corollary to this is that the land is extremely fertile and agriculture plays a large part in the economy. The land is mainly flat with the exception of Chittagong (near the border of Burma) which is considerably more hilly. There are a great many rivers in Bangladesh and this influences the diet of the people which is considerably high in fish. The capital Dhaka is centrally located and I was based here for most of my short stay. Bangladesh like most third world countries is a land of contrast especially when it comes to the socioeconomic spread. It is paradoxical in having some of the richest people in the world living next to some of the poorest.

Elective Objectives

When planning my elective I had a number of objectives. Those in Bangladesh, included undertaking a Cardiovascular Risk Factor Project. There is growing interest in the underlying genetics of atherosclerosis genesis and I felt this would be an ideal opportunity to add to this area of research.I would like to thank Professor Swaminathan for all his help and encouragement. The other objective was to experience Tropical and Third World Medicine as it would probably be an area of medicine I would not have the opportunity to experience again.

The Holy Family Red Crescent Hospital (HFRC)

My time in Bangladesh was centred around two institutions. Most of my clinical experience was gained at the Holy Family Red Crescent Hospital. I am deeply indebted to Dr. Kaniz Moula and Dr. M A Wahab for all their efforts to accommodate me and make me feel part of the team.

The Hospital was founded on 15th March 1953 by the Catholic Medical Missionary Society. During its short history it was declared a safe and neutral area during the 1971 war and in that same year it was handed over to the Red Cross and then later to the Red Crescent Society in 1988. The first Superintendent was Sister Mary Benedict Young and at that time in 1953 there were 100 beds and a small nursing school.

At present there are 340 beds, 51 consultants and 70 junior doctors, 190 nursing staff and 100 nursing students. Clinical departments include Medicine, Surgery, Obstetrics and Gynaecology, Paediatrics, Coronary Care Unit, ENT, Ophthalmology, Psychiatry, Neurosurgery, Neurology, Orthopaedics, Urogenitary medicine, Pathology, Radiology, Ultrasound, Endoscopy, Dental Department, Anaesthesia, Accident and Emergency and Physiotherapy.

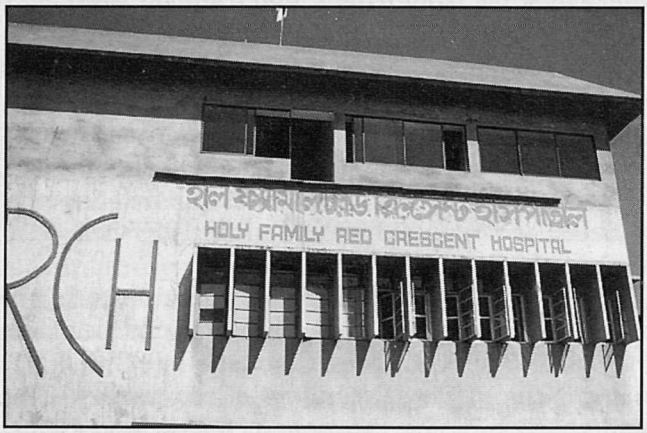
The system of healthcare provision is largely a fee-based system, however the HFRC is noted for 40% of its patients being cared for free of charge. The expense is borne by the Board of Trustees. The HFRC is also noted for being recognized for postgraduate training for the FCPS examination in Medicine (the equivalent of MRCP). I was working mainly with the medical teams under Dr. Kaniz Moula and Dr. M A Wahab.

The day was split between ward rounds and outpatient clinic. The rounds lasted between 3-4 hours with a substantial number of inpatients seen and discussed amongst the team. The system of rounding was essentially the same as that we are used to in the UK. I was able to see first hand a wide range of conditions. Tuberculosis is still a common disease(1) as are the infective forms of hepatitis. Enteric fever is widespread and takes up a large part of the hospital admissions(2).

Cases of interest

Some cases of note included an elderly man with end stage liver disease who developed massive ascites and subsequent encephalopathy secondary to this condition. He was treated for his liver failure and underwent a paracentesis which proved successful. It was surprising to see the large number of cirrhotic

patients. The main aetiology being infective hepatitis, in contrast to the large number of alcoholic cirrhotics seen in the UK(3). Another interesting case was that of a young man of 18 years who was brought into the hospital after falling into a river while playing with friends. He was lucky to survive as he did not know how to swim. After an episode of mild pulmonary oedema he made a swift recovery. One of the registrars commented on the fact that in a country surrounded by water it was almost a crime to not be able to swim, we agreed and then moved on to the question of what to call the final diagnosis. The registrar said 'drowning' but I was quick to correct him 'an *unsuccessful* drowning' which brought a smile to the consultant's face.



The patients were investigated to a similar standard as in the UK. There was widespread use of various imaging studies such as MRI and CT scan. These were either done at the hospital or at one of the many diagnostic centres in Dhaka. Those who could not afford the tests themselves were paid for by the hospital Trustees.

The outpatient clinics were extremely busy. This was an added bonus for me. The throughput of patients meant that again I experienced many different cases. One in particular was that of what I thought was a rather innocuous case of pityriasis versicolor. By testing sensation around the area and a careful history the registrar soon set me right with the correct spot diagnosis of a lesion characteristic of leprosy.

Dhaka Medical College and Salimullah Medical College

The clinical experience gained at HFRC was matched by the research experience gained at Dhaka Medical College (DMC) and Salimullah Medical College, and an added bonus of meeting a very charming and dedicated group

of medical students. From a personal perspective I feel I gained much from the students and their relentless efforts to help me. I must also mention one person in particular without whose efforts the project work would not have taken place: Mr. Iftekar Zaman (Sonny). Dhaka Medical College and Salimullah are UK recognized institutions. The medical course is similar to that of the UK being a 5 year course. I was involved with first and second year students who proved to be most cooperative.

Dr. A K Azad is a very enthusiastic Assistant Professor in Biochemistry at DMC, who is much appreciated by his students. He has been instrumental in setting up the Medical Information Group in DMC. This is a voluntary organization that promotes the free flow of medical knowledge and encourages medical research amongst students and doctors. It was through his influence that I was able to get such a good response from the students.

Another notable point in my adventure was giving a small lecture to the students regarding my project. This to me presented a considerable hurdle. I considered speaking in Bengali but I am sad to admit that their English was far superior to my Bengali (the entire course is in English). I felt that audience soon warmed to me more out of sympathy then any outstanding academic prowess. I explained the nature of the project in terms of helping us to understand better the genetic basis of cardiovascular disease and also the stages of the project.

The Project

The stages of the project included taking a fasting blood and urine sample and certain arthropometric measurements such as height, weight, skinfold thickness and blood pressure. There was also a health questionnaire. This was not an easy task to undertake for 100 students. The students were entered into the study in the evening at which point all the arthropometric measurements, the questionnaire and blood pressures were taken. The students were then instructed not to eat or drink anything after 10 pm. The samples were taken early next morning before breakfast.

The samples were taken to the Padna Diagnostic Centre, Dhaka where they were spun down and stored. I am indebted to the lab there and in particular Mr. Harun El-Rashid who gave me free range of his lab without charge. A visiting team from India showing the finer points of using the newly acquired

auto-analyser gave myself and Sonny a great source of entertainment, but that's a different story.

There was a significant difference between the males and females taking part in the study when it came to *vaso-vagals* at the sight of a needle; the boys did a lot worse. Although the scientific explanation for this still confounds me. I remember one particular day when a male student took one look at my vacutainer and proceeded to keel over. I remember vaguely someone in the distant past telling me 'raise the legs up above the level of the head. I did so and while in the process witnessed one myoclonic jerk. I could hear *'ABC'* racing through my head and the thought of the Bangladesh Observer headline reading *'visiting medical student leaves student as vegetable after research project'*. Luckily the jerk was an isolated phenomenon and the student soon recovered fully *without any neurological deficit.* Unfortunately the sight of one student fainting soon set off the rest of the group. Needless to say that was not a good day for collecting samples.

There were many logistical problems to the project including the recent political instability in Bangladesh. The Opposition party had called a number of General strikes known as Hortals. This together with the fact that there were a few national holidays meant that sample collection was severely hampered. Sonny (whose help was invaluable during the project) summed up my frustrations with the well used expression 'Bloody holidays and dash Hortals'. I assume the dash was to be replaced with some other expletive.

I was nearly disallowed from taking the samples on the plane and only given clearance by telex twenty minutes before the flight was due to leave for Heathrow. The journey to the airport had been a traumatic experience in itself. My flight was booked on one of the many days of Hortals. I had to reach the airport despite the ban on cars. An ambulance with its sirens blazing and me in the back wih my white coat and stethoscope was to serve as a subtle subterfuge. We had had to accelerate rather sharply as we approached an angry mob, but the sound of the sirens and our rapid rate of approach made even the staunchest supporter think twice about stopping our progress. Someone had pointed it out to me that an over-enthusiastic group had stopped an ambulance the day before and set it alight. Nevertheless I put these obstacles down to experience and can only thank those many individuals who came to my aid.

Experiences in Chittagong

I was also lucky enough to visit another part of Bangladesh during my busy schedule, Chittagong. This is a port city and an industrial centre. Here I managed to experience a rural hospital in Chondonish which was far removed from HFRC or the Medical Colleges in Chittagong and Dhaka. There were 30 beds, 15 of which were occupied by malaria patients. Chondonish is a malaria endemic area. Paediatric cases included many infants below the age of six months with respiratory tract infections. Diarrhoeal disease is a major killer in infants. Programmes of health education with saline/glucose drinks have reduced this. Now a major problem is that of respiratory tract infection(4). Another programme has been started in this area to combat this. I was also surprised to be told that in a single outpatient clinic there may be upto 200-250 patients; a far cry from Guy's outpatients.

I was also rather disturbed by another experience during my elective visit to Bangladesh. I was told of what was described as a *Herbalist Mental Hospital.* Curiosity got the better of me and I went to visit it. The belief was that a particular type of tree would *remove the madness.* The patients were literally incarcerated in between two long beams of wood. From what I saw the only purpose of these was to restrain the patients. Many of the patients I saw clearly were suffering from treatable mental illness. I asked how the patients had been brought there and was informed it was through the wishes of their family. I was shocked to view such a practice going on in Twentieth Century but assured that this was not a widespread practice and isolated to a few rural areas.

Conclusion

Bangladesh is a third world country struggling under the many stresses that this label brings. When it comes to health care provision there are many paradoxes. The standard of health care provision varies enormously. From the excellence of the HFRC Hospital to the disturbing views at Chondonish. The health care issues in Bangladesh are obviously different from those in the UK. Primary health care needs are to be addressed especially rigorously in the rural areas. Many of the conditions seen could be drastically reduced by basic hygiene and education on health issues. In the UK, TB was considerably reduced in the 1950's not due to the introduction of chemotherapy but mainly through basic improvements in hygiene and nutritional status. Improving the

nutritional status of the population as a whole is a complex problem that involves many spheres of influence other than medicine, in fact it has very little to do with medicine.

We in the UK believe that our resources are limited, well you only have to look around you to see what really limited resources are. Yet the profession in Bangladesh has a way of treating as many people as possible even though admittedly it is failing a large proportion.

Contact with the student population also brought a lot of hope to me for this virgin nation. There were many Programmes set up and run by students to help people in Bangladesh. In particular a programme of blood donation and corneal transplant. The students are extremely resourceful and bright as evident by their efforts to realise my project goals. The Medical Information Group is yet another example of their ingenuity and shows their commitment to medical research.

I feel that my time in Bangladesh has opened my eyes to another branch of medical practice that I would not have otherwise seen. In particular the amazing efforts made by the healthcare profession in Bangladesh despite the major lack of funds. I would recommend an elective period of study in the Third World and in particular in Bangladesh as it will broaden your view of medicine and perhaps some other areas too.

References

1. The Annual meeting symposium IV. International co-operation in Tuberculosis control-Global strategy and the role of Japan. Kekkaku 69(1) 31-53, 1994 Jan

2. Patterns of morbidity and mortality in typhoid fever dependent on age and gender. A review of 552 hospitalised patients with diarrhoea. Butler T, Islam A, Kabir I Jones PK. Reviews of Infectious Diseases 13(1) 85-90.1991 Jan-Feb.

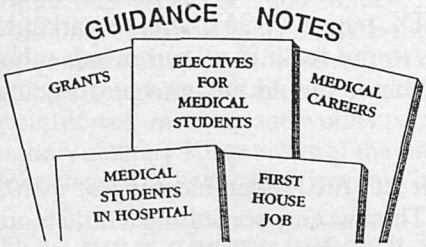
3. Cirrhosis. P Kumar M Clark. Clinical Medicine. Chapter 5 260,1994

4. Levels, trends and causes of mortality in children below 5 years of age in Bangladesh: findings from a national survey. Salway SM Nasim SM. Journal of Diarroheal Diseases Research 12(3):187-93, 1994 Sep.

Alamgir Kabir

ARE YOU A MEMBER?

BMA



OTHER BENEFITS FROM THE BMA:

* BMJ/Student BMJ
* BMA News Review every month
* Free Guidance Notes
* Individual Advice

OTHER BENEFITS FROM BMA SERVICES LTD:

* New Elective Travel Insurance Policy
* Advice on first Mortgages
* Car Hire Discounts
* Medical Equipment at Discounted Prices
* Student Loans

COME AND MEET US AT OUR REGULAR TALKS
HELD IN THE STUDENT BAR

FOOD AVAILABLE

March 22

The House Officer Experience
Team Working

Dr Stella Lowry: Head of BMA International Dept.
UMDS House Officer
My Job as a House Officer

'Dare Quam Accipere'

More than just a motto!

The following article represents the full text of a clinical lecture given in 1945 by TB Layton, D.S.O., M.S. The article has been reprinted from the 1945 volume of Guy's Gazette (Vol. LIX, pages 24-26). This remarkable lecture has been chosen for its wisdom, to put fresh in all our minds what it means to be a doctor and moreover what it should mean to us all being Guy's men and women.

GENTLEMAN, - When we search into the hidden meaning of men's deeds we find in each of those of Thomas Guy something a little more than there is in those of most. In nothing that we know of him was this more evident than in his choice of a motto for his Hospital.

I believe that in that we have a revealing item of autobiography. But while he was trying to carry into his daily tasks the teaching that it is more blessed to give than to receive, the conception of human life was very different from what it is to-day. It postulated that by the fact of their birth there were some who were above the rest and that this rest descended by varying degrees to what were called the lower classes, the *canaille*, the scum of humanity. These were there because they were everlastingly doomed to the position as a part of Nature. In the anatomical terminology of to-day, men's genes were different between the classes. Some had within their cells the hereditary genes of aristocracy and were entitled to a life of ease. It was permissible for them to perform with impunity deeds that would have given a stigma of original sin to the scum; while these were doomed in the sweat of their faces to provide the motive power that could produce the needs of those that toiled not. Under such an hypothesis of human life there was no chance or raising the lower classes above their destined status; but there were kind and good people who wanted to relieve the suffering of the poor. This was done by deeds aided by money; but as time went on money took first place and deeds were relegated to the paid secretaries of charitable institutions. It is this charity that many worthy people have resented being compelled to receive of recent years. It is of this a virile young lady politician spoke when, in a local brains trust, she said, in reference to a question on the Beveridge Report: 'We want to get rid of the very smell of charity.'

To-day we live under a different dispensation. It is one that believes we are dedicated to the proposition that all men are created equal.

And so I want you to-day to consider how you can carry into your work at Guy's, and after you leave it, the principle of our founder under which you enrolled when you joined us. The problem is how are we to carry out in our work as doctors under the new dispensation that all men are created equal, the principle that it is more blessed to give than to receive? There is a tendency to-day to vaunt ourselves, not so much as Guy's men and women, but as members and representatives of the Voluntary Hospitals. This is a fake form of patriotism and to some extent may be condoned; but when it becomes marked it does harm to the very organisations which it seems to puff up, and carried to excess it becomes unseemly. There is a group of well-meaning and worthy persons who seem to believe that all work done at the Voluntary Hospitals is of the first rate; that by the mere fact of of its being done there it is better than it would have been had it been done in a municipal hospital, and that all work done in these is doomed to be second rate. I will not admit the truth of any of these three hypotheses. I resent most bitterly the imputation that the little children upon whom I have operated by the hundred in the municipal hospitals have been less well cared for by myself, by medical officers, or by the nursing staff than have the much smaller number who have been under my care here. And so I would ask you not to thank your God you are not as other men, condemned to an inferiority of labour. There is no aristocracy of medicine. There is room for improvement - always, everywhere. Lane once said to me: 'You must always have an ideal; but you must never attain to it, for when you find yourself doing so you must put it further away.' But the more fact that you were trained at Guy's and did your clinical medicine in the wards of a Voluntary Hospital is no guarantee that you are raising the standard, always, everywhere.

'You must always have an ideal; but you must never attain to it, for when you fine yourself doing so you must put it further away.'

Only one or two of you will remain or return here for your life's work and when you go elsewhere and see work which is undoubtedly inferior, but which all around accept as right, do not at once go telling them what you did at Guy's; think first whether there was anything done here and accepted by all as good, which hit the outsider's eye as being bad. Then and not till then you are in a position to try to improve that which is poor where you are, to correct that which is wrong. It is not the institution that you found when entered it that matters; it is the one you

leave. English medicine will be raised throughout the Empire by doing good work and by this alone, not by exalting one group of institutions.

And the next way in which I would ask you to try to carry out the principle that it is more blessed to give than to receive is by paying a minute attention to detail. Lane once said to me that he had never known a death under anaesthesia that was not due to carelessness or inexperience, and usually to both. I did not, even then, like his use of the word 'carelessness', but substitute for it 'want of attention to minute detail'-and my experience is as his. Remember that death under anaesthesia is not the only tragedy in all medicine. It is a blatantly irrecoverable one. In all others either you have the processes of Nature irretrievably against you, or, by their healing powers, they mask the results of your want of attention to detail. There is no better example of this principle in the whole of medicine than the treatment of discharging ears in children. Once we have decided there is no immediate danger to life we are inclined to let things slide. But there is that other risk to life that arises from chronic disease, and you are responsible for that death if you have refrained from doing some minute detail during the acute stage of the disease. Mind you, it may be very boring. Day after day to try to teach young women how to make a twiddle of wool with which efficiently to mop an ear, week after week to remove those little bits of wet epithelium against the drum-head that they have been unable to get up, but which prevent the final healing. These require the greatest perseverance. Great operations can only be done by a meticulous care and attention. If these are not forthcoming the mortality becomes so high that the operation dies a natural death. The same care is needed in the lesser surgical procedures to prevent morbidity. This leads to early death later; but we have hardly entered into the stage of surgery where the prevention of morbidity is considered as important as mortality. In this the obstetricians have given us a lead. If we consider humanity as well as the human being. As much benefit will ensure to it by the prevention of morbidity by small measures as by salvage from death by great ones. They must be done by all - by care and by attention to detail. There is no limelight in it. The light that is needed is that enthusiasm for humanity which changes work from being a feeble restraining power to an inspiring passion.

'You do not make a man a fencer by putting a rapier in his hand. You do not make a student a doctor by handing him a diploma.'

Please remember that this applies to medicine as well as to surgery. The coming of the new drugs has produced just as great a revolution in the former as antiseptics

did in the latter. Their application and administration need as great an attention to detail as does the running of a modern operating theatre; but with their coming there is a tendency for the older medicine to be forgotten just as has been the older surgery, The preparations of opium and the purgatives are weapons to be used, not to be thrown about, and their use implies a minute attention to detail and constant practice. You do not make a man a fencer by putting a rapier in his hand. You do not make a student a doctor by handing him a diploma. These drugs afford instances of a great deterioration in medicine compared with that of my youth. Doctors cannot use these two groups in a way their predecessors did. You must give thought, observation and attention of your own to them, and not merely receive reports from nurses.

'The view is put around by your teachers and the organisers of your work that the medical student is a delicate little darling that cannot arrive before 9.30 a.m. or even 10 a.m. '

The next way in which you can give more than you receive is to start work early. If you do this no one can catch you up during the day. Do not think I find it easy to be early. Though I wake early I find it just as hard to get out of bed as you do; and I am very fond of dawdling when I have done so. It is not from ease that I have tried for over twenty years to get my dressers to attend at 9 a.m. on Monday morning. It is because I think work in hospitals should start at that time, and that doctors should be in their wards by 9.30 a.m. In this we are deplorably behind other countries. But it is not only that. The view is put around by your teachers and the organisers of your work that the medical student is a delicate little darling that cannot arrive before 9.30 a.m. or even 10 a.m. I will believe that these teachers are sincere when they themselves turn up at 9 a.m. and spend that half-hour in doing all the little oddments that service to a great hospital demands; but I will not believe even then that they are right. I lived in the City in the great 'blitz' and I heard your sisters tramping to their work, scrunching the broken glass in the dark; and then was told our students could not do the same. What is the use of your football and your other games if you are to be pampered by your teachers into little milk-sops thus? At other hospitals I know that lectures are still given at 9 a.m. and I know they get a theatre full.

Go then through your week's work and think how in everything you do can give more than you receive. A smile to a child, a pat on the shoulder to the mother to give that little extra confidence that will help the medicine you order. Encour-

agement to the young to remain at work, a chosen word to convince those in middle age they have no dread disease. A shift of your position so that you can get the best out of your hands in their examination, a refusal to start that examination until the accommodation at your disposal is placed to the best advantage.

'And when we are dead we shall be forgotten utterly except in the hearts of those few people in South London to whom we were kind when we tended them.'

You may say that these are all small things in which I have been failing all my life. What right have I come and preach to you? It is because I have failed that I have that right. I should have failed constantly in all these things even if I had known early of their importance. But I might have done so less often if it were not that between the wars we worshipped false gods. We all wanted to be great, and we thought that money was an end. A world-wide reputation and a loaded banking account whereby to purchase it. And when we are dead we shall be forgotten utterly except in the hearts of those few people in South London to whom we were kind when we tended them. Set your minds on the little things and the little people. Chance the world-wide reputation. Live more fully in the hearts of men than my generation have done.

But life is not all giving and there is something you receive at Guy's and that we did receive, pressed down and running over. That is the right - nay, the duty - to doubt everything your teacher tells you. There is to-day a sad setback in the way that this is meted out to you. There is so much to know that it has to be hammered in. Text books take up too much of your time. Lectures have been chopped and replaced by innumerable tutorial classes which are crowded into the middle of the day so that students have to leave the wards and clinics before time, thus chipping still more their length already shortened by the late beginning. But chiefly is it the way you are taught. To sit around while a physician shuffles papers, or a surgeon examines the patient and, instead of compelling to do the same, just talks. Thus are you reduced from the status of university students to that of goody-goody little schoolboys. But still there is your ancient heritage, not yet quite waned, of your right to doubt, a right that you can only claim by personal observation and independence of mind. Lane,

'That is the right - nay, the duty - to doubt everything your teacher tells you.'

who spoke badly, though he could spin words into golden webs that will last the ages, once said to me: 'If ever there is anything in surgery on which everyone is agreed it is almost certain to be wrong'. I have found that to be true. If you go out into the world with this spirit within you, you will have received from Guy's something that will compel you to give much in order to attain to the blessedness of '*Dare Quam Accipere*.'

T.B Layton was Throat surgeon to Guy's Hospital until 1948. He died in 1969 and his obituary, appears in the 1969 volume of the Gazette.

NEW SUBSCRIBER
BANKERS ORDER SUBSCRIPTION FORM

Photocopies are acceptable

Please return completed form to:

Guy's Gazette

Boland House
Guy's Hospital
St Thomas' Street
London SE1 9RT
Tel 0171 955 5000 ext 5413/5414

To the Manager

_____ Bank plc

_____ Branch

_____ Address

_____

Please pay the sum of £15.00 annually on _____
commencing 19____ to the credit of:

Guy's Hospital Gazette
Account No. 80401269
Midland Bank plc
Southwark Branch
28 Borough High Street
London SE1 1YB

and debit my account accordingly:

Name (please print) _____

Account No. _____

Address _____

_____

Signature _____ **Date** _____

An Interview with Professor Brookes

Not Quite Retired!

Professor Murray Brookes has been associated with Guy's Hospital for most of his life, including 35 years in the Department of Anatomy. After studying pre-clinical medicine at Oxford, he continued his clinical training at Guy's. There followed houseman posts in Yorkshire, and then 2 years of national service in Germany which he completed in 1955. Whilst in Germany, he applied to 22 British universities, and was lucky to get a research post in Liverpool with Professor Ronald Harrison where he stayed for 7 years. It was here that his research led to pioneering developments in the blood supply of bones. In 1962, he joined Guy's Department of Anatomy as a senior lecturer under Professor Warwick, was awarded the title of Professor in 1983, and remained at Guy's until his retirement in 1991.

What made you pursue an academic career rather than a clinical one?

I had always enjoyed anatomy at Oxford with Le Gros Clarke and Solly Zuckerman. Although I enjoyed clinical practice, the thought occurred to me that I didn't really want to spend my life doing thousands of tonsillectomies or appendicectomies and so I decided to apply for a post as an anatomist.

Were you ever tempted to work abroad?

During the 1950s, the conditions for graduates were deplorable due to the lack of expenditure on research, which resulted in a tremendous 'brain-drain'. This was the only time that I was seriously tempted to move abroad as many of my peers had done. However, with the change in Government, the climate changed and research was promoted as they finally realised that without research, our economy would stagnate and so I stayed. After all, despite

travelling throughout Europe, I am always relieved to return home and I feel that England is the most amiable country in the world.

What research have you concentrated on during your career ? Why bones ?

Whilst studying at Oxford, one of the required texts was 'The Tissues of the Body' by Le Gros Clarke. Upon studying this text, I noticed that very little was known about the blood supply of bone and so I decided to investigate this further. I eventually showed that the blood supply comes from the medulla and spreads outwards to the cortex, until in old-age the periosteal supply becomes dominant. I also researched the beneficial use of intramedullary nails in bone fractures and some of the intricacies of orthopaedic practice.

After moving to Guy's, I lectured in embryology but maintained my interest in osteology and went on to devise methods of measuring the blood supply of bone. The environment at Guy's made research very enjoyable. Not only was I surrounded by eminent scientists such as Professors Warwick, Williams, Joseph, and Osbourne, but there was a great sense of cameraderie and co-operation between the different departments which were all situated so close together. There were no departmental walls.

What are your main reminiscences from your time at Guy's?

I think it was mainly the people I came across during my training. The chief physician, Sir John Conybeare, I will never forget, mainly for the fact that he continually urged us 'always do a PR'. I also remember the time when Conybeare dismissed a female patient with an apparent intra-abdominal condition, within the first few minutes of seeing her, as a psychiatric case, much to the horror of his registrar! I was taught surgery by Sammy Wass whom I remember operating on a dock worker who was brought in after falling on a ship-hook which completely degloved the soft tissues of his face. The day after the operation, the patient was sitting up in bed, smoking a cigarette.

I am sure that other former Guy's students who trained during the late 1940s will remember Sir Heneage Ogilvie, another eminent surgeon. He was very

well liked, possibly for the reason that he used to take his firm out for dinner to the Royal College of Surgeons at least twice a year; and of course, Lord Brock, whom I met when I was a fifth year student. A man on a medical ward apparently had gout in his hands but my diagnosis was that of a thoracic tumour with pulmonary osteoarthropathy. During the ward round, we spent ages discussing gout until I was allowed to speak. I assisted Lord Brock in the removal of an enormous pulmonary ganglionoma from the patient's chest!

What pastimes did you have whilst at Guy's?

I have never been a 'card carrying, golf playing' member of any academic club but I have always been interested in the many things that enlighten our lives such as politics, poetry, classical music, art and literature. I firmly believe that an appreciation of these facets of life are essential for doctors, not only to establish a rapport with patients, but also with colleagues. Of course, science is an essential part of life too as it offers explanations for natural phenomena. For example, try talking to a person who has no scientific understanding; you will find that they live in an almost animistic world. This is why I think that it is imperative that the politicians who control our country should all have a science A-levels at least. Without this, I feel that our country cannot avoid political cataclysm.

What are your views concerning the proposed changes at Guy's?

I think that as the medical school enlarges on the Guy's campus, it will eventually become more of an Institute and as such, I am sure that it will survive for many years to come. However, I cannot help but fear its divorce from the Hospital, particularly with the re-siting of the majority of clinical departments at St Thomas'can do nothing but harm. Also, with increase in size, I don't think that the best teaching is possible.

What have you been doing since your retirement?

I have been writing a textbook and atlas of embryology for the past 5 years which I eventually finished yesterday. I am currently the secretary for the International Anatomical Nomenclature Committee (IANC), a faculty mem-

ber for a Franco-German orthopaedic conference and up until last year, was Founder member and Vice President for the International Association for Circulatory Research (ARCO), based in Toulouse. I fully intend to continue working until I drop!

PGH

Guy's Hospital - 250 years

Have you ever wanted to know more about the history of Guy's? What was student life like in the nineteenth century medical school? What happened in the Resident's Plays of the Forties and Fifties? How about nursing, midwifery, the Wills Library? Or the early days of X-rays?

This 240 page, illustrated paperback gives a history of the achievements in every field of Guy's life for the past 250 years, and is available for only £2.95, including postage and packing, from the Gazette office. The book makes an ideal gift, and only a limited number are available.

Please send cheques or postal orders, made payable to Guy's Gazette, to Guy's Hospital - 250 Years, Guy's Gazette, Boland House, London SE1 9RT

Medilinks

Last week, a demonstration version of 'Medilinks' was sent to the office for review. I duly loaded the program up on the computer expecting the type of 'medicine-for-toddlers' program that is popular with the major American software companies at present. However, I was pleasantly surprised when I unravelled the package...it was great. What's more, the program is British!

'Medilinks' is marketed as a computer reference system based on the medical curriculum that can easily be modernised and customised to the individual user's needs and is aimed primarily at medical students, junior doctors, nursing staff, and allied healthcare professionals. It boasts over 20, 000 topics and all the major specialities in both medicine and surgery are covered. Within each speciality, the information is divided into at least three basic axes; basic knowledge, clinical features, and diseases & conditions. These are then subdivided into epidemiology, pathology etc. and it is this structuring of data throughout the program combined with its user-friendly layout that makes Medilinks so easy to use.

However, that being said, £168.50 (£84.25 for students) is a lot to pay for a program which is essentially a textbook packaged into a different medium. After all, £170 can buy a lot of text books (and more besides) but it is the unique features of the program such as its updateable design and the cross-referencing feature that make this program a viable alternative, or at least addition to, standard medical textbooks.

The ability of the user to add his/her own notes to the program, whether this is just simple annotations to the text, new cross-reference links, or even entirely new entries, ensures that Medilinks will continuously remain up to date.

The cross-referencing feature of the program is possibly the best aspect of Medilinks. This enables the user to relate the condition that he/she has just read with other similar conditions. This is accomplished with semantic links such as 'may be caused by...' or 'may cause...'. Thus, differential diagnoses can be easily found and in a manner that aids the student during revision.

This is definitely a program that should be considered if you are bored with reading textbooks and need justification for spending possibly over £1000 on a computer for Christmas.

(Medilinks, Butterworth Heinemann, ISBN 0705616563)

PGH

Gynaecology by Ten Teachers

For those with great expectations of the latest edition of this highly acclaimed textbook, will be most annoyed to find that the standard of the sixteenth edition is well below par. It is difficult to be critical of the content of the book because before one can do so, one has to overcome the enormous number of proof reading and typesetting errors. Such mistakes are not good for the general appearance of the book and they interfere with the fluency of reading the text.

Although primarily aimed at the undergraduate market, disappointingly this book contains far too much minute detail and not enough emphasis on basic core knowledge. The inclusion of new topics such as AIDS, urology and HRT makes this edition as up to date as any other in its class, and is competitively priced. The arrival of new teachers, including the chairman of UMDS division of Obstetrics & Gynaecology may draw many discerning students in to purchasing this book but be warned value for money and suitability, this book is not. Gynaecology by Ten Teachers (Arnold, ISBN 0340573155, £15.99).

D Sen

Anatomical Pathology

As the structure of exams becomes more OSCE - based, the visual recognition of pathological processes becomes even more important. Combined with the fact that the ability to visualise a particular condition aids understanding, a colour atlas is now almost essential for the pathology student.

'Anatomical Pathology', 2nd edition, is one such atlas that would be ideal for all those learning histopathology. Its 272 pages contain over 600 colour photographs of macroscopic pathological specimens, many revised since the first edition, and are all accompanied by a concise and helpful explanation.

For those who do not have the time or access to a pathology museum or post-mortem room, this book provides an excellent substitute and is highly recommended for all those trying to study the vast subject of pathology.

Churchill Livingstone, Cooke & Stewart £29.50 ISBN 0443050627

PGH

Pretest StudyDisks

Most will agree that MCQ revision books are one of the best ways to polish one's knowledge prior to an exam.One problem is, however, that the books tend to be rather unappealing to read. McGraw Hill has attempted to overcome this problem by publishing several 'study disks' for 'Windows' and 'Macintosh' computers.

Each program contains 500 questions but the difference between this and other MCQ books is that the user can customise the program by altering the content or number of questions that can be asked and the time allowed to answer each question, thereby allowing personalised practise examinations to reinforce weak areas for example. The results of each test performance can then be printed out, the analysis of which can be used to develop a more effective revision plan.

The topics available at present include Anatomy, Biochemistry, Microbiology, Pathology, Pharmacology, and Physiology. The main program reviewed in this article was the physiology studydisk.

Installation of the program was very easy and the layout of the program is very clear. The physiology studydisk is divided into sections on metabolism, endocrinology, CVS, Respiratory system, renal & acid-base physiology, gastrointestinal system, neurophysiology, and cellular physiology and the majority of the basic medical science course is covered.

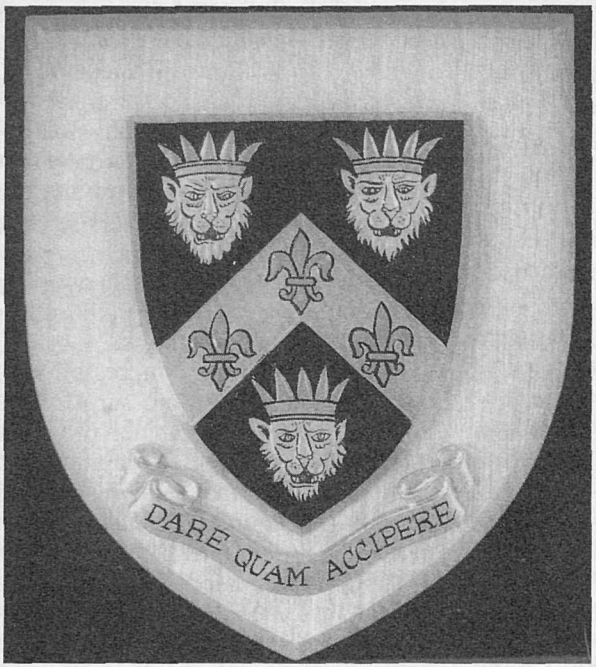
The explanations of each question are particularly impressive with references to the major textbooks.

Overall, I was very impressed with the studydisks. They are surprisingly inexpensive for a computer program, offer a wide range of information in a customisable format, and manage to present MCQs in a way that is a little more easy to cope with than standard textbooks. Of course, their use relies on the fact that you have access to a computer and this is one set of MCQs that you cannot put in your bag and read on the tube (unless of course you have a laptop).**Physiology Study Disk, (Blackwell Science ISBN 007864156X, £17.50).**

PGH

Guy's Hospital MEMORABILIA

Unique items available only from the Gazette



Hand painted Guy's crests mounted on a selection of woods. These make ideal gifts for any Guy's man or woman. Just what you need to decorate your surgery or study!

Price £22 each + £1 p&p

To: The Manager
Guy's Hospital Gazette
Boland House
St Thomas' Street
London SE1 9RT

I enclose a cheque/PO for £ .....
NAME: .....
ADDRESS: .....
.....
.....

Please make cheques payable to Guy's Hospital Gazette

Office hours: Monday to Friday 1-5 pm. Personal callers welcome.

THEN AS NOW

In recent months posters on the London Underground have depicted two illustrations by Dora Carrington of Lytton Strachey. Some may have seen the exhibition or film which these posters advertised; but the tall willowy figure of Lytton Strachey in these pictures is reprinted on the cover of a book which I have recently read. This is one of the works for which Lytton Strachey is justly renowned - 'Eminent Victorians'.

Amongst the portraits of those who were eminent in the Victorian era, is that of Florence Nightingale. Miss Nightingale is recalled as the founder of modern nursing, and is rightly remembered in this role through the establishment associated with Guy's and now known as The Nightingale Institute.

Lytton Strachey starts his description of Florence Nightingale thus: 'Every one knows the popular conception of Florence Nightingale. The saintly, self-sacrificing woman, the delicate maiden of high degree who threw aside the pleasures of a life of ease to succour the afflicted, the Lady with the Lamp, gliding through the horrors of the hospital at Scutari, and consecrating with the radiance of her goodness the dying soldier's couch - the vision is familiar to all. But the truth was different.' Indeed Florence Nightingale had many battles of her own, with those of the highest authority in the government of this land.

Amongst those most in opposition to her plans for changing the way nurses did their work were members of the medical profession. Apart from a few honourable exceptions, she was frustrated at Scutari by doctors who had created a barrack hospital which was a 'filthy, verminous, stinking' place. Later, in her proposals for the royal Victoria Military Hospital at Netley, built for the 'brave heroes' of the Crimea, she found she was too late to prevent the erection of a grandiose, but 'uncomfortable and insanitary' building. The Nightingale Training School for Nurses at St Thomas' was established, we would do well to remember, in the face of opposition from one of that hospital's senior consulting surgeons who argued that nurses were 'in the position of housemaids' and needed no special training.

I wonder how many of the medical profession continue to endorse his idea, if in some updated form, today? Certainly, as nurses continue to follow a line of 'Nightingalization', there have been voices expressing dislike of modern nursing training and research. Training today is more professional than it has ever been, and some doctors believe, puts nurses above their station of simply providing care to the sick. And, as for research, one medical writer recently suggested that nurses

were unable to understand statistical significance and the tests used to prove this, and should therefore not make any pretence in engaging themselves in this area.

There was also the doctor who thought nurses were too tied up in bureaucracy and pursuing their own professional careers to bother about what happened to patients. He may have a point about the red tape: but then, who is to blame for that? Furthermore one critic thought nurses should stay beside the bedsides of patients, and not involve their pretty little heads with matters best decided by medical 'experts'.

This is all quite contrary to the modern approach to nursing, and there are a variety of papers, written by nurses, which have shown how care has been delivered more profitably, developed, and improved as a result of nursing research, as opposed to medical research.

So many obvious factors, often commonsense ones, are neglected by doctors; nurses have not only improved their care for patients, but have often shown how to make economic advantage. Florence Nightingale was not there just to sooth the fevered brow. She fought, and remained a fighter, throughout her long life. In late years she received an admirer, the Aga Khan, of whom she said: 'A most interesting man, but you could never teach him sanitation'.

Denis Cobell.

GUY'S HOSPITAL NURSES LEAGUE

Many senior readers of the Gazette will have been kept up to date with all the changes at Guy's and must wonder what is happening now to Guy's nurses.

For in the days when many of them were student doctors, dentists, physiotherapists and radiographers the hospital was staffed almost entirely by Guy's trained nurses. Renowned for the high standard of their patient care, and working the extremely long hours that were required of all nurses, they none the less helped to provide a great deal of the social life at Guy's and many a good wife has been selected from among them over the years! They have frequently held high positions of responsibility in hospitals, schools of nursing and all fields of the Nursing profession, as indeed they still do. In the 'fifties and 'sixties wearers of that well known Guy's badge could find work anywhere in the world and other Guy's trainees working abroad will have encountered them in many countries. Today the School of Nursing at Guy's no longer exists. Nurses train in the Nightingale Institute, now fully integrated members of Kings College, London University. However the Guy's Hospital Nurses' League remains a vibrant society. They meet at Guy's every May for their AGM and keep up to date with hospital news and with each other. They hold a lunch

alternative years in October, still have frequent 'set' reunions and have just had their first regional reunion. The Benevolent Fund is healthier than ever before, helping many members of the League, and each year the Scholarship Fund gives help with the expenses of further education for Guy's trained nurses. New members are warmly welcomed, the requirements for membership being three years of working at Guy's, and anyone interested in joining the League should telephone the League Office on 0171-955-5000 Extn: 5463. On Saturday 14th October this year the Nurses' League held their biennial lunch in the Robens' Suite. The principal guests on this occasion were the Right Rev Bishop Maurice Wood, Assistant Bishop of London, and his wife who is herself a Guy's nurse. Before sitting down to lunch we asked Bishop Maurice to say the Guy's Grace which he wrote in 1985, dedicated to his friend Dr Anthony Batty Shaw who presided that year at the biennial dinner of the Guy's East Anglian Society. Other members of Guy's may like to read this, and possibly even use it for their own reunions. So the Guy's Hospital Nurses' League is indeed alive and well and, as you will have seen from a recent advertisement in the Gazette (others will follow) a great day of celebrations is planned for May 11th 1996. This will mark the end of an era at Guy's and all Guy's men and women are welcome to join us at this celebration - we hope very many of you will.

Margaret Lamb

A GUY'S GRACE

O God our heavenly father who taught us in scripture 'Dare Quam Accipere', help us not only to receive these gifts of your bounty with thanksgiving, but so to give ourselves with skill and patient care to all in need, that they may receive your blessings of healing and wholeness, which you give, and which are the enduring principles of our great hospital. For this food, for our friendship, and for Guy's, past, present, and future, we praise you in the name of our Lord Jesus Christ, the incomparable physician of our souls.

AMEN

Annette McGowan

Annette Martine McGowan (nee Fanning) RGN, ENB 176, DMS, Operating Theatre Sister Guy's and St Thomas' Hospital Trust. Born 9 January 1964, died 18 October 1995, aged 31.

Annette was one of those rare and lovely people who once seen are never forgotten. She possessed many unique qualities, not least of which were her wonderful sense of humour, her enthusiasm for life and her unselfishness, devotion and support of others. Born in London of charming Irish parents, Annette trained as a nurse in Ireland at Waterford Regional Hospital and qualified as a Registered General Nurse in 1986. She moved over to England and Guy's Hospital in March 1987 to undertake the English National Board 176 Operating Theatre Course. Thereafter, Annette remained an employee of either Guy's or St Thomas' Hospitals and, eventually, the Trust. After qualifying from her Theatre course, Annette worked in the Main Theatre Unit at Guy's. Following spans of duty between the Urology and Cardiothoracic Theatres as a Senior Staff Nurse, she transferred over to the newly re-commissioned Guy's Nuffield Hospital to take up her first Sister's post in the Theatre Department in February 1990. In November 1992 Annette moved over to St Thomas' Hospital to become the Sister of the Cardiothoracic Theatres. Annette was diagnosed as having stomach cancer in November 1993 and embarked upon an arduous regime of chemotherapy and radiotherapy. Despite this devastating illness, she remained positive, cheerful, determined and, in the face of ad-

versity, continued to live as normal life as possible. Throughout all of this, Annette never lost her zest for life and made the best of every opportunity. In the summer of 1994 she successfully completed a Post-Graduate Diploma in Management in between her chemotherapy regimes and numerous hospital admissions. Annette was instrumental in the smooth merger of Adult Cardiac Theatre services to St Thomas' from the Brook Hospital. This involved her being a key member of the team responsible for the re-commissioning of the new East Wing Theatre Suite. Throughout this great period of change, Annette remained committed to and concerned for her staff, friends and colleagues. Her selflessness was one of her truly great virtues. Annette managed to achieve her last three wishes; to marry in her favourite church in Fermoy, County Cork, to return to England to die and to be buried in Fermoy. Annette was a truly special person. Her courage and determination were an inspiration to others. She will be sorely missed and forever in her hearts. She is survived by her husband, Simon.

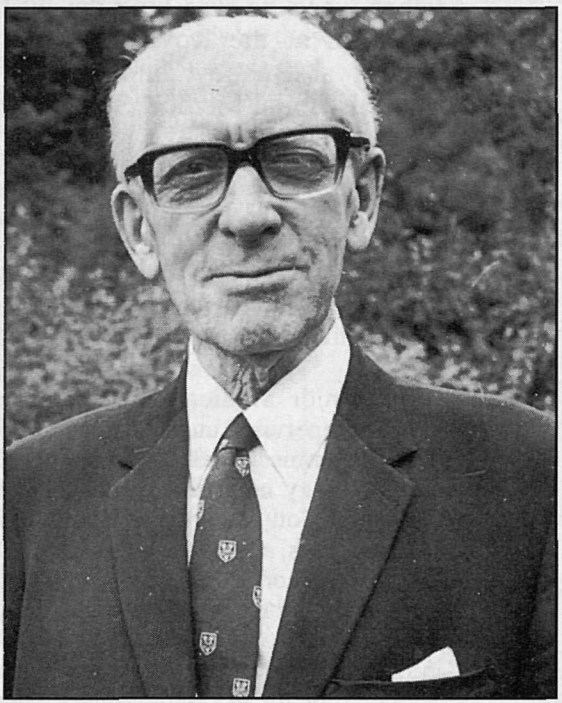
Ian McColl.

Dudley Grasby

E.D.Y.Grasby, MD., FRCOG. (1903-1995). Dudley Grasby, who died on 30th October 1995, was born into a naval family in Teignmouth in 1903. On the death of his father when he was nine, he was educated at the Royal Masonic School at Bushey, and entered Guy's Hospital Medical School on a scholarship in 1921, aged 17, qualifying in 1926. In July 1928 he took up a one-year appointment as Resident Medical Officer at Pembury Infirmary, a former Poor Law Institution, and was persuaded to remain there for the rest of his career.

As Senior Medical Officer from 1930 he supervised an extensive building programme including new theatres, the pathology laboratory, a children's unit, provision for acute medical and surgical cases, a new X-ray department and nurses' home. What was now the County Hospital at Pembury remained in the Guy's sector, and in 1937 he was informed by the Emergency Medical Service director in London that if war was declared, Pembury was to be a principal Base Hospital to deal with war casualties. Dudley Grasby had tried to join the R.N.V.R., but to the relief of the Emergency Medical Service, had been turned down because he failed the eye tests. He had now to

provide 1000 extra beds for possible casualties; to accommodate these, temporary single-storey wooden wards were erected in the grounds, the work being completed by the outbreak of war in 1939. To augment the staff, Guy's Hospital seconded senior surgeons to Pembury, as well as Registrars and



nurses. They included his old chief, Phillip Turner, whose House Surgeon he had been at Guy's, John Carter Braine and Archie Marston. Dudley Grasby was appointed Surgeon Superintendent of Pembury Hospital, and having obtained his M.D. in 1938, specialised in Obstetrics and Gynaecology. Pembury had a busy war with civilian and military casualties of many nationalities. His instructions were to stay at his position if invaded and run the Hospital for casualties from both sides. He tended pilots from the RAF, the Luftwaffe and Polish squadron during the Battle of Britain, and Pembury was a clearing hospital for the Dunkirk casualties. Before the war he had pioneered at Pembury a new attitude to health care which asserted that everyone should have access to the highest possible quality of medical treatment, regardless of ability to pay. He therefore welcomed wholeheartedly the establishment of the National Health Service in 1948. As the Guy's staff left, so he enjoyed the friendship of new colleagues such as Norman Jacoby, Ivor Thomas, John Mayer and Malcolm Henderson. He resigned from the post of Surgeon Superintendent and was appointed Chairman of the Medical Committee formed by the NHS. He became consultant in Obstetrics and Gynaecology, and built up a private practice from his home, first in Matfield and then in Tunbridge Wells. He was invited to join the panel of examiners for the London MB and for the Royal College of Obstetricians and

Gynaecologists. Forty-two years after qualifying, he retired in 1968, and lived in Hawkhurst. In 1930 he had married Peggy Coldicott, they had two children, and eventually five grandchildren and two great-grandchildren. Peggy died in 1982, but Dudley remained in his usual sparkling health until a very short time before his death. He was a man of great energy and firmly-held ideals. He had many talents and interests: he would have liked to study law as much as medicine, and did indeed sit some examinations. His gifts as artist and musician were perhaps not enough practised in his busy life, but as student at Guy's he wrote, produced and performed in the annual Residents' Play and Concert Parties. He loved going to concerts and plays, particularly musicals; he was a member of the Haydn-Mozart Society for may years, attending all of their concerts. He was immensely inventive, working out practical answers to mechanical problems, both at work and at home. He was a keen tennis and golf player, an excellent swimmer, and enjoyed shooting. After retirement he was able to travel more, particularly to Greece and Italy, and for a time owned a house in Malta, an island which had been his home for a time as a young man; he was a natural linguist. He loved giving and going to parties. Many will remember him as a man of strong faith; he was a committed Freemason from a young age, and rose to high office on the Province of Kent. Above all, he will be remembered by grateful patients.

R Grasby

HUNTER, George Leonard BDS, LDS RCS (1947-53). Died November 28th 1995 aged 69. He served in the Royal Navy until 1943. He was a former Ist XV rugby player and captain of Gravesend Rugby Football Club.

PUSEY, Roy. Died August 11th 1995. A chapel service held at Guy's was attended by many of his former colleagues.

Rugby

Cranleigh v Guy's Hospital
Courage League: 28th October 1995
WON 24-12

Guy's began this match looking an absolute shambles. The Guy's kit had been left back at the hospital and they took the field with one player short, Breeze having not arrived. In spite of the fact that IInds and IIIrds were also playing at Cranleigh, they had kicked off before the Ist XV and were thus not able to provide a substitute. Cranleigh kindly loaned Guy's some shirts and with a prop on the wing the Guy's side achieved fifteen players in an assortment of jerseys.

Not surprisingly, Guy's were totally disorganised at the start and the Cranleigh scrum half gratefully accepted the yawning gaps which appeared, to run over for the first score. This at least stimulated the Guy's side to further effort and they camped on the Cranleighan line for some time without turning that pressure into points. They were unlucky when a pass was intercepted and their wing round the makeshift Guy's wing for a converted try. Thankfully Guy's maintained their running game and two quick tries through Graham Lawton and Greg Ryan both converted by Davies took Guy's into the lead and settled down the side. Both tries were the result of quick handling. A third try was scored by Murphy in the corner. Guy's were beginning to exert some control and a rolling maul took the ball up the left hand side of the field to take the half-time score to 19-12. By this time Breeze and his damaged car had arrived at Cranleigh and an injury to Knuckles on left wing allowed him to take up his normal post. Guy's had given ample indication in the first half that, in spite of letting in two tries, they were perfectly capable of taking this game by the scruff of the neck and winning. We looked forward to a more expansive second half. Breeze almost made his presence felt immediately when with a long mazey run he thought he had scored only to be brought back for a double movement. Gush increased the lead when he scored in the corner allowing the Guy's touch judge to feel involved in the game after discussion with the competitive back row from Cranleighans. In spite of another couple of penalties, that remained the final score. However, there were a couple of incidents involving most of the pack to indicate that both sides were keen to compete. Davis played a very sound and abrasive game and with Greg Ryan and Challacombe made inroads into the opposition midfield. However in contrast to recent weeks on several occasions Guys lost the ball in tackle or maul. However, in the end Guy's ran out worthy winners by 24 points to 12 and thoroughly deserved

their win which takes them into mid place in the League. Team: D Baladasoran, D Evans, L Hostert, B Challacombe (Captain) E Barrio, P Davis, G Ryan, A Knuckles, J Murphy, N Davies, R Breeze, N Jenkins, G Lawton, P. Gush, M Rose.

SJC

Guy's 1st XV v Old Wimbledonians,
24th November 1995, H.O.P

Guy's entertained Old Wimbledonians from London 2 on a dull November afternoon at HOP with some changes in the 1st XV line up from the previous week.

Although not a league game the fixture derived from the league system since in their season of promotion two years ago Guy's were the only side to beat Old Wimbledonians. Once again the Guy's pack found themselves considerably smaller than the opposition and it was clear that the possession was going to be a problem. As it transpired this was correct and not helped by blatant lifting in the line out by the opposition which went completely unnoticed or at least unpenalised by the referee. For the first 20 minutes Guy's won remarkably little possession but were able to show their extreme capabilities in tackling. Terrific tackling all round the team kept the opposition at bay and in fact Guy's took the lead with a penalty by Neil Davies. However Old Wimbledonians resumed the attack and when the referee gave them an extra 10 yards for an inappropriate word of advice to the referee from a member of the Guy's side, they were caught unorganised and the opposition second row crashed over for a try. Guy's gradually began to get a little more possession and in fact reached half time in the lead 9-8 following two splendid drop goals by Neil Davies. Newcomer James Dinsmore in the back row had been outstanding in a series of devastating tackles and constructive set-ups. As concentration lapsed a little in the second half, Old Wimbledonians moved into the lead with two tries one of which was well worked. The remainder of the game was very even with both sides trying to run the ball but with both defences dominant. It made for an entertaining spectacle and although Guy's pressed continuously for the last 15 minutes Old Wimbledonians were winners by 20-9 which was scant reward for a very even match and tremendous commitment by the Guy's side. Guy's running game is very attractive to watch and they will beat many sides with their inventive rugby. Team: D Baladasaran, I Jones, Lutz Hostert, M Ansell, B Challacombe (Capt), W Llewellyn, G Ryan, J Dinsmore, J Murphy, N Davies, P Gush, M Jenkins, J Davies, G Lawton.

SJC

Guy's Ist XV v Old Reigations.
The Boulger Cup
7 October 1995 Away

Alex Boulger and James Hawker were our two students killed almost exactly three years ago on their way to a match for Guy's at Bath.

Alex was a pupil at Reigate before coming to Guy's, and the Alex Boulger Cup was donated by the family for Guy's and Old Reigations to play an annual match. On the last two occasions Guy's have won it and this was the third annual fixtures. Guy's were showing a few changes from the previous week after the injuries to Barrio and Scott and the unavailability of Rose. Guy's drew first blood where after an excellent quick ball captured in the loose it was sped along the line to the opposite corner for Bevan to score. At this stage in the game Guy's were looking very comfortable winning their own though not the opposition line out and their own and not the opposition scrums. All the opening pressure was on Old Reigations with both the forwards and the backs involved and it was somewhat of a surprise when after a scrum and blindside move, Old Reigations scored a converted try to take the lead. Guys then launched waves of free flowing rugby and after a missed touch in the Guy's twenty-five the ball passed through the whole team, forwards and backs, before Murphy scored in the corner. Outstanding in the first half had been the two wings both of whom scored. Bevan was actively involved in many of the moves and Breeze on the other wing who once outpacing his opposite wing only just failed to score with a ball chipped past him and on another occasion just failing to hold on, to a long pass when clear. Nevertheless the impression was of a team wanting to play good rugby with Ryan and Llewellyn securing a lot of ball in the loose and Murphy and Davies at half back orchestrating the attacks. Having got the bit between their teeth Guy's proceeded to play some excellent rugby certainly impressing the home supporters if not their team. The ball was moved quickly from all parts of the field and forwards and backs joined in a series of flowing movements. Unfortunately on one of these attacks the ball was dropped and the offer of a try was gleefully accepted by the opposition wing to take Old Reigations back to an undeserved lead. However Guy's continued to run everything and once again a classy move with backs and forwards again showing the ability to draw a man before passing led to another try in the corner by Bevan converted by Davies. This restored Guy's lead at 17 points to 14 but shortly afterwards Reigations levelled the score with the penalty. It was beginning to look as if the Boulger Cup might be shared for the first time when a Guy's ball was halted on the opposition ten yard line and the referee spotted the hand of the Reigations second row coming between the legs of the

Guy's captain and squeezing something other than rugby ball. Davies kicked the subsequent penalty for Guy's to win the game 20 points to 17 and when Challacombe had got his breath back he was able to emphasise the truth of the catchphrase "no pain no gain" and that it had been a worthwhile sacrifice in the interests of the team. Altogether this was a very fine performance by the Guy's side playing enjoyable and skilful rugby. They thorough deserved their win and have now won the Boulger Cup for three years in succession against a side higher in the leagues than ourselves. For Guy's Bevan was always in the action either physically or vocally and played an excellent supporting game as did Breeze who was unlucky not to collect a try or two. Jenkins and Brown played solidly in the centre and Brown looked a much more accomplished player at centre than he had done a couple of weeks earlier at fly half. A feature of the game was the excellent defence all round the side including a crushing tackle from Baladasaran in the middle of the pitch against the opposition centre and Guy's once gain showed that on a dry pitch they can be a match for most sides. Let us hope that the rain stays clear for the whole of the winter and particularly for the league games to come.

Team: D Baladasaran, F O'Sullivan, L Mostert, B Challacombe (Captain), M Ansell, G Ryan, W Llewellyn, M Sharp, J Murphy, N Davies, G Bevan, R Brown, M Jenkins, R Breeze, A N Other.

SJC

UMDS BOAT CLUB

1995 Summer Tour
Stourport, Won: Men's coxed fours.

This trip to the West Country gave the boat club its first chance to win some races during the summer, the men hoping to clean up in novice IV+s and the women hoping to do well in senior 3 IV+.

The first races saw comprehensive wins recorded for both sides of the club. The next round of the women's division saw them come up against a good crew from Notts B.C., and unfortunately they lost by around a length. However, the men carried all before them, and on their way to winning the novice IV+ category, saw off opposition from Warwick, Llandaff 'B', Bath Univesity and Llandaff 'A', beating the last named crew in the final by an emphatic three lengths. Our mixed VIII, entered for a bit of fun, was unsurprisingly beaten by Stourport R.C.'s mixed VIII consisting of their mens open IV and womens senior 1 IV.

A barbecue and camp fire was started that evening, before we visited the marquee in Stourport's 'enclosure'. Sunday's racing was slightly less successful, the men's IV+ beating their first opponents in senior 3 very comfortably, but never quite recovering from a poor start in the second race, succumbing by half a length to Lensbury. The ladies were similarly beaten by the eventual winners from Stratford-upon-Avon, after pulling out half a lengths lead, having had the better start. Despite the Sunday defeats, however, we were in very good spirits as we packed up; could we score more wins in the Great West Country tour, coming over the bank holiday weekend?

Gloucester, Bristol and Ross. Won: Men's Senior 3 VIIIs

Three days of partying / rowing were looked forward to by the mens squad, after the ladies had trouble getting a crew together. This started in Gloucester, where a peaceful night's sleep under the stars was followed by our first race in our umpteenth scratch line-up. An 'iffy' race was had by both the VIII and IV+, but we had some degree of cohesion as we won each by just over a length. However, the next round of the VIIIs race saw us beaten soundly by Lensbury, who went on to win overall, whilst the IV was knocked out by Gloucester. After finishing with our commitments here, we headed off to Bristol, to the lair of Captain Baird.

After a mediocre days rowing, we were determined to go out at Bristol Avon and give it our best shot. The coxed four raced first, and despite a better row, we were beaten by the winners, UCL. However, this just steeled everybody up to do better still in the VIII. Our hapless opposition in the first

round were Bath University, who were swept away by more than two lengths - an emphatic win. Confidence was bouyant after that display, and we carried it with us in the boat to trounce Bewdley in the next round by another two length margin. This took us into the final, with a re-run of the previous day's race, against Lensbury. Sure of our ability, we were desperate to avenge our defeat by this crew, and rowed to the start, high on adrenaline. Good starts by both crews saw us level, but two mighty pushes each gained us half a length, and we crossed the finish line over a length clear. Needless to say, we were very pleased by the win, as in doing so we won the Peter Bathe Taylor memorial cup (I don't know who he was, but the trophy was very large and very shiny!). Celebrations all round that night, as several people accompanied us back to our BBQ, retiring to bed in the wee small hours.

An early start was needed next morning, however, as we had to travel to Ross-on-Wye. A powerful row by our IV+ saw us win both heats, against Monkton Bluefriars school, and the UCL crew that had beaten us the day before (revenge *is* sweet). Likewise, the VIII was still performing well, as we won both of these heats to move into the final. Ultimately, however, we were beaten narrowly (1/4 length) by Chester R.C., after losing about half a length at the start. Despite this setback, we were starting to close them down, and simply did not have enough river left in which to pass them. After this disappointing and narrow defeat, we had to race in the final of the coxed fours, and despite the best efforts of the crew to revive themselves for this event, succombed to York City R.C,. albeit by only a length.

All in all, it was a successful weekend, and importantly, everyone had a whale of a time. The win at Bristol was no more than we deserved, and with a little more luck we could have repeated this feat at Ross.

Steve Arnold

Football

2nd XI v St George's II
BUSA Cup: Draw 2-2

Following the weekend victory, UMDS II were set a more challenging task, against a side recently relegated from the Division above.

Arguably, in the first half UMDS were outclassed and were struggling to get the ball out of their own half. This was further aggravated by difficulties amongst the centre backs, who were second XI debutants. The lack of pressure was granting degrees of animosity amongst a youthful mid-field, and this was capitulated in the first of St. Georges early first half goals. Poor defending again was to blame for the second concession and now UMDS were faced with a real struggle to stay in the game. The half-time whistle was a welcomed relief, as we were given an opportunity to rationalise our play. Tanning words from the captain were reassuring and sparked some hope of turning the game around. Indeed the second half was played in complete contrast to the first. The centre backs had undergone a metamorphosis from 'hoofers to Pallisters', and not a single ball went past them. The ball was being won more and more often and UMDS were catching the George's big men 'ball watching'. It was inevitable that from such inspired play that a goal should come. It came towards the middle of the second half by neat one touch football amongst the midfield, orchestrated by Imi , and was finished by Kuram for his first for the season. The pace of the game had been lifted and before long a second was added for UMDS by the experienced feet of Ollie which were welcomed back openly. In the closing minutes, the confidence flowing through the 'Blue and Gold Army'. UMDS were unlucky not to grab the winner. Through the courageous efforts of Nifio, who's unforseen 'faced' effort just stayed wide of the post. In all a well deserved draw for the home side, and still yet to be defeated.

Team: Arji, Lai'Hook, Mike 'Hooker', Tim, Riki, Neil, Kuram, Imi, Chidi, Nifio, Ollie, Squash

RT

Memorial Fund

A memorial fund is being set up for Dr Jacqueline Ford and colleagues who were killed in a crash in South Africa in the latter part of 1995. Donations may be sent to :

BethesdaMission
c/o Dr Ian Swan
10 Newton
Bradford on Avon
Wilts BA15 1NE

Annual Dinner

South Wales Guy's Hospital Society

The next dinner will be held at 7.15 pm in the Wedgewood Suite, Park Hotel, Cardiff on 16th March 1996 on the night of the Wales vs. France International rugby game.

All UMDS students, graduates, nurses, therapists and their partners are invited to attend. Speakers include Mr Richard Haskell, Senior Consultant in Oral and Maxillo-facial Surgery at Guy's and Consultant Physician, Dr Terrence Gibson. Those interested in attending should contact Mr D E Sturdy, Rothesay, 22 Stow Park Circle, Newport, Gwent 0163 3264646.

Dental Day

This years Dental Society Clinical Day is to be held on the 2nd March 1996. The programme starts at 9.30 with the Herbert Memorial Lecture to be given by Professor Edwina Kidd.

Practice for Sale

A busy, long established, three surgery dental practice with own parking in Bexleyheath, Kent, is for sale as the vendor wishes to retire shortly.

Equipment all renewed within last two years, premises in good decorative order. 30% of gross turnover private, with scope for expansion. For further details, please contact:

I W Torry on 01959 523775

MB BS Pass List

The following candidates successfully passed the Final MB BS (London) December 1995:

Ahmed, A R
Alakeson, Miss R
Barnwal, Miss A
Chao, N S Y
Chelveerajah, R
Chow, K Y
Davies, R J E
Evans, S M
Haque, Miss S J
Hirche, F K G
Hundal, R S
Islam, Miss V
Jagethesan, Miss T
Jayawardene, S A
Kapur, S K
Khan, S S
Kumar, P
Lams, E J
Patel, H K B
Patel, Miss Y
Qureshi, T R
Saad, A
Shanmuganathan, V A
Siddiqi, M F
Weir, R E P
Williams, P S

BDS Pass list

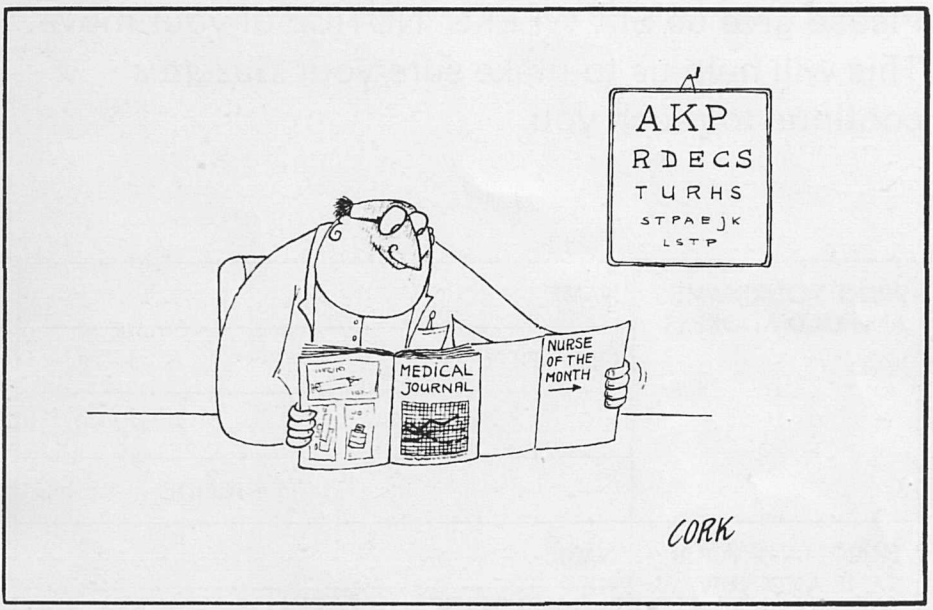
The following candidates qualified BDS (London) in November 1995:

Marouf Saghakhaneh, Miss N
Sanehi, P S

Raffle

The 1995 Gazette Raffle was held on the 14th December. The following were drawn as winners:
1st Prize - Rupert, Special Trustees, No. 013540
2nd Prize - Miss A E Moore, Surrey, No. 006587
3rd Prize -E S Bates, Birmingham No. 011100
4th Prize - D E Hone, Kent No. 009501
5th Prize - Dr G Baker, Surrey No. 011029
6th Prize - P J Tombleson, E Sussex No. 019272
7th Prize - Michael Taylor, Gosport No. 012572
8th Prize - Frank Ashley, Croydon No. 014199
9th Prize J F Sharp, Ipswich No. 010913
10th Prize - D A Davies, Somerset No. 013315

We thank all entrants for their support.


AKP
RDECS
TURHS
STPAEJK
LSTP
MEDICAL JOURNAL
NURSE OF THE MONTH
CORK

Changing Your Address?

Please give us SIX WEEKS' NOTICE of your move. This will help us to make sure your *Gazettes* continue to reach you.

PRINT YOUR NAME AND **OLD** ADDRESS	NAME
	OLD ADDRESS
	POSTCODE
THEN PRINT YOUR NAME AND **NEW** ADDRESS HERE	NAME
	NEW ADDRESS
	POSTCODE

Now cut out this coupon and send to:

Guy's Hospital Gazette
Boland House
Guy's Hospital
London Bridge
London SE1 9RT

GUY'S

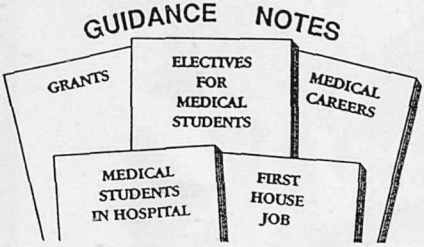
HOSPITAL GAZETTE

February/March 1996

- Elective Report—Harvard
- Interview with Dr Cochrane
- Bright's Disease

ARE YOU A MEMBER?

BMA



OTHER BENEFITS FROM THE BMA:

* BMJ/Student BMJ
* BMA News Review every month
* Free Guidance Notes
* Individual Advice

OTHER BENEFITS FROM BMA SERVICES LTD:

* New Elective Travel Insurance Policy
* Advice on first Mortgages
* Car Hire Discounts
* Medical Equipment at Discounted Prices
* Student Loans

COME AND MEET US AT OUR REGULAR TALKS
HELD IN THE STUDENT BAR

BUFFET LUNCH

April 19
1 o'clock

'Contracts and Pay'

Mr. David Barr: BMA Industrial Relations Officer

CONTENTS

50 Passim
51 Letters—Future of Guy's RFC
53 News
55 Feature—Elective Report—Harvard
62 Feature—Interview with Dr Mac Cochrane
69 Feature—Bright's Disease
79 Reviews—Psychiatry, Statistics, Pharmacology
82 Nursing Notes—New Approach to Practice?
85 Obituaries—David Lipscombe, James Allardice
88 Sport—Rugby, Rowing, Women's Football
96 Classifieds and Announcements

Guy's Gazette

Editor Rikin Trivedi **Assistant Editor** Paul Hayden **Sub Editor** Sue Ferguson **Features Editor** Kate Mundray **Sports Editor** John Davies **Nursing Notes** Denis Cobell **Office Manager** Margaret Flanders. **Acknowledgement** Dean Flanders.

The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

Volume 110 Number 2454 February/March 1996
ISSN 0017–5870

Guy's Gazette, Boland House, Guy's Hospital, London SE1 9RT.
Tel (0171) 955 5000 ext 5413. All rights reserved.

Printed by Hobbs the Printers Ltd, Brunel Road, Totton, Hampshire SO40 3YS

Passim

At the time of writing, the country is suffering its coldest winter for years. Snow, ice and biting winds chill the cheeks, but how much worse is the cold hand of Government which is freezing the heart of the Health Service.

Year by year the number of acute admissions to hospital is increasing everywhere. Yet the number of beds available for the sick who need them is deliberately being reduced. We are all familiar with stories of patients lying for hours on trolleys in Accident and Emergency Departments until beds are found; of doctors and senior nurses making dozens of telephone calls to other hospitals to find a vacant bed; of patients being transferred at all hours and sometimes having to travel a long way from their homes; of elective operations being cancelled again and again because an emergency has to be accommodated somewhere. Dangerous patients with psychiatric illnesses are sent out into 'the community' because their beds are needed for more dangerous ones.

How does the Department of Health respond to this? By making banal comments about there being 'no shortage of beds' and it being a problem for 'local managers and clinicians to solve'. If it were possible to solve the problems locally, pressure to do so, and the amount of time spent on trying, should by now have brought solutions, but conspicuous failure is only too evident. Doctors do not any longer admit patients to hospital unnecessarily, large numbers of managers, many of whom are competent, cannot produce empty beds where none exist. It is a national failure and a national disgrace, for which this Government is responsible through failure of funding and perverse priorities. It is surprising that with a general election so close, and disaffection so deep and widespread, the Secretary of State is not prepared to do more for those who need his help the most - the sick, and, more cynically perhaps, for his colegues who will badly need the votes

Guy's RFC - The End?

Dear Sir,

Below is a copy of a letter, one of several of its kind, offering the opinion of members of GHRFC concerning the future name of the Club. I hope it is of interest to you:

Dear Lord Butterfield,

I write to you as a member of Guy's Hospital RFC regarding the formal discussion that will take place at the forthcoming Board of Governors Meeting, on 4 December, involving the official name of the rugby club that represents UMDS.

This is my fifth season playing both Saturday and Wednesday rugby. I have always thought that I have played for the same club, the only difference being that the Wednesday team was restricted to current students at UMDS. It was only at the EGM held a short time ago that I learnt from Prof. Chantler that two different constitutions existed. Prof. Chantler also seemed to share the widespread opinion that the Wednesday team named Guy's & St. Thomas's Hospitals is the vestiges of the old St. Thomas's Hospital RFC. This view, spread throughout the student body mostly by individuals who are staunchly 'anti-Guy's' and have never laced a pair of rugby boots, is incorrect. Guy's Hospital RFC survived as such after the merger mainly due to the efforts of Dr Terry Gibson to keep graduates who had qualified at Guy's playing for the club. The people in the St. Thomas's RFC lost all interest in running their club. Guy's Hospital RFC did not bury St. Thomas's RFC, the latter died a natural death due to the lack of enthusiasm of its members. It has remained only in name in the Hospital's Cup competition in order to keep the number of teams in the Cup at a reasonable level and to involve as many players as possible in the famed competition.

The Wednesday rugby team was a product of Guy's Hospital RFC deciding to put out a side, for students only, under the name of Guy's & St Thomas' Hospitals. It was the first club at UMDS to do so. On Saturday the club competes in the Courage League, in which it is known as the Oldest Club in the World, and involves students, 'old boys' and other players with indirect links to Guy's Hospital.

I am completely in favour of one rugby club with one constitution. I believed that to be the situation in any case. However, I think that the name of this club should remain as Guy's Hospital RFC. It is of historical importance and it is what the members of the club wish. I also think it an insult to the committee and players who worked so hard for the survival of a successful

club, whilst members of the St Thomas' RFC showed apathy at theirs disintegration, that it should be otherwise suggested. Idleness should not be rewarded in this way.

Yours faithfully,

Edward A. Barrio Frojan
Club Captain, 1993-94

NB. According to individuals present at the meeting no support was forthcoming from any individual outside GHRFC. In fact, the Chairman was absent from the meeting and the letters lay unopened on the table. It is comforting to see that decisions concerning established institutions at UMDS are made (by individuals with no link to such institutions) with such consideration for their members' opinions. Guy's Hospital Rugby Football Club is dead. We'll miss it, they won't!

Rugby News

Ugo Ekeowa, a 4th year Medical Student at UMDS has recently been selected to play for the English Universities team. He currently plays as left winger for Guy's 1st XV and for Blackheath. His first match is against the Irish Universities team.

Restorative President

David Davidson, a Guy's Dental School graduate in 1969, has recently been honoured with the Presidency of th British Society for Restorative Dentistry for 1996.

Gazette Internet

In keeping with the multimedia revolution that is encircling the world, Guy's Gazette now has its own 'home page' on the internet and e-mail address. This can be accessed via g-gazette@UMDS.ac.uk

Guy's Hospital Gazette

English Pewter 1 pt Tankards, Engraved with the Guy's Crest, available only from the *Gazette*, individually boxed.

Price £22+£1p&p

ORDER FORM

Name .....

Address .....

.....

Please send me . . . . . Guy's Tankards at £22+£1 p&p

I enclose a remittance of £.....

To: The Manager, Guy's Gazette Office,
Guy's Hospital, London SE1 9RT
Tel: 0171 955 5000 ext 5413
Personal Callers Welcome

Office hours: Monday to Friday 1–5 p.m.

Elective Report part II

Horses for courses

The second half of my elective was spent in a totally different part of the world: the USA. I spent a short period of study at the Brigham and Womens, one of the Harvard Medical School affiliated Hospitals. Harvard is situated in Boston and has a typical New England feel to it. I was lucky to go at a time when New England is at its best i.e. the fall. I had heard many things about the colours of the countryside in this region and I am happy to report that they were all true. Boston was a very pleasant city and this was matched by the friendly nature of the people. Perhaps one might attribute this to holiday fever blinding my judgement, but I still feel that the people were genuinely more friendly.

I stayed at Vanderbilt hall which was a short walk through the Medical School Buildings to the Brigham. The Brigham and Womens is the amalgamation of three hospitals and has a reputation for its teaching. Harvard as as a whole is an extremely well to do institution. Walking through the Medical School Buildings each morning one could not but help but be impressed by the surrounding architecture. The hospital itself was in a large institution and there were some parts which resembled more a five star hotel than a hospital. There were no wards as such and the maximum number in a room was two. Every room had its own television, with cable of course, which at times got a little ridiculous. Even the Medical and Surgical Intensive Care Units had televisions. Perhaps this was more for the nurses than the patients considering their extremely fragile state of health.

'The hospital...resembled more a five star hotel than a hospital. There were no wards as such and the maximum number in a room was two'.

Elective objectives

My objectives on this part of my elective were to experience the other side of medicine. That which could be described as at the cutting edge. I wanted to contrast my experiences in Bangladesh with those I obtained in Harvard. I also had heard a lot about the American practice of medicine and wanted to see how it related to what I had learnt back in the UK.

'Management was heavily influenced by current medical literature. Rounds would inevitably involve the use of references that each of us would obtain beforehand.'

I undertook an Attachment in Gastroenterology. This proved to have a great deal of relevance to other specialities as well as being a vast subject in its own right. I was especially keen on the pancreatic diseases as well as hepatology. The AIDS related gastroenterologic pathology was also particularly important and useful for me to see. The Brigham is also a major endoscopy unit. I spent my time between two Attendings, Dr Stephen Zucker and Dr Peter Banks, both of whom I am very grateful to for all their efforts.

The Gastro Team

I was working on the Gastroenterology consult service. The function of this team was partly to answer referrals from other teams. As such I was allowed to see many different patients where their gastro problem was but one of many. I felt that I was given a lot of responsibility for the patients allocated to me and was involved heavily in their management plans. I would write my assessment and plan as well as a detailed justification of my decisions. The attending would review this on the rounds and countersign my notes. Management was heavily influenced by current medical literature. Rounds would inevitably involve the use of references that each of us would obtain before hand. I also had experience in outpatients as well as endoscopy clinics.

Initially I must admit I had difficulty adapting to the system. The abbreviations used took some getting use too. For example 'HEENT': give up? So did I and on asking was told 'Head Eyes Ears Nose and Throat'. This was okay to ask once or twice but at times things became a little embarrassing. I remember asking someone what C-H-O-L stood for, only to be told cholesterol. Although

the note-taking was essentially the same there was much more emphasis on previous investigations and less of clinical findings. I found the use of SOAP notes for follow up quite helpful. This stood for, Subjective, Objective, Assessment and Plan.

Another useful aspect of my attachment was the regular conferences that were held. These were also notable for their pizza. I was also very impressed by the free flow of information. People covered a smaller field but they knew that particular area arguably better than anyone else. The conferences were specifically designed to allow people with different gastroenterologic interests to view and discuss other colleagues' cases.

Cases of interest

Some cases which I thought were particularly interesting included that of a young woman with a history of abdominal pain which predated her now seven month pregnancy. The team deliberated the question of what to do. Options included colonoscopy, laparotomy or as with most management plans, to do nothing. The management plans were quite interventional and seem to be more aggressive. In this case a laparotomy was decided upon and it paid off. The lady was diagnosed with a Dukes C2 tumour. Her symptoms rapidly improved and she is due to undergo other therapies post-delivery.

'The two factors that I felt were notable were that the management plans were far more invasive in nature and aggressive. Also, once the decisions had been taken they were acted on very promptly.'

Another case was that of an intensive care unit patient who had a GI bleed after a T Tube had been inserted for feeding. I still remember the picture of the T tube burrowing into his gut wall and the definitive diagnosis being made after this endoscope. The site of bleeding was injected and the T tube was then removed.

AIDS related gut pathology can be very varied and I saw a lot of oesophageal ulceration due to CMV and HSV. The hepatology again proved to have a lot to do with AIDS patients and also ethanol induced damage. This contrasted

with my experiences in Bangladesh where infective hepatitis was the major cause of end stage liver disease.

Another case was that of a gentleman who presented with iron deficiency anaemia on a routine blood test. Colonoscopy showed a large mass in the ascending colon. This brought home to me the inconspicuous nature of right sided colonic neoplasm. He was operated on the very next day. This showed a Dukes B carcinoma.

The two factors that I felt were notable were that the management plans were far more invasive in nature and aggressive. Also, once the decisions had been taken they were acted on very promptly.

Students

I found that students at Harvard were extremely focused in on their goals. Students had very fixed ideas about what they wanted to specialise in. The study of medicine is a post-graduate subject and lasts four years in the States. I was told an estimate of $40 000 a year for tuition and other requirements during the course. This together with the fact that the students are a lot older probably explains their different attitude toward their curriculum.

'Students at Harvard were extremely focused in their goals...together with the fact that they are a lot older probably explains their different attitude towards their curriculum'

Computers

Computers play a heavy part of both student life and the hospital. Every student is given a personal organiser (HP 200LX) and access to the Harvard Medical School computer network. This has an extensive array of articles and other useful features. The hospital has at least 4-5 computers on each ward. There is access to a regularly updated medical literature database. E-mail is available to communicate between colleagues and is an extensively used system to carry out orders. Medical Informatics and the use of computers seem to have reached a happy compromise even at the Attending level.

Conclusion

I enjoyed my time in the States. The aggressive nature of the care plans probably reflected greater resources spent on healthcare. I think this type of care is suited to the American expectations from their doctors. One might say that patients are over investigated however the patients want that level of care. Perhaps in the UK patients will respect the doctors option to do nothing and wait and see. Although the dynamic state of care healthcare in this country may mean that we are heading the American way too.

'As doctors we need to learn to be adaptable. Medicine is constantly changing and whether we like it or not we need to change with it.'

The treatment of students at the Brigham was something to be admired. I liked the amount of responsibility given to students for their patients. The system of countersigning was very useful. I think that as a newly qualified doctor getting to grips with the burden of responsibility is definitely a major bridge to cross. The American way of teaching students seems to lessen the gap between student and doctor.

Overall the American practice of medicine is something that I was pleasantly surprised at. The greater reliance on investigation of patients and less on clinical signs did I feel at times put the patient through unnecessary procedures. However the counter argument to this is that investigations are usually more definitive.

Contrasting the two systems

I managed to visit two different parts of the world and I intentionally chose these because I wanted to see how the medical professions around the world differ and what they share in common. The technically advanced Harvard way of approaching the patient meant that they received a very high standard of care. However in Bangladesh, with rather limited resources the approach may have been less technical but this is not to say that the patients were not treated well.

The issues at stake in a third world country are far removed from those in the so called developed world. Primary health care and improving the awareness of basic health issues for the population are paramount in Bangladesh.

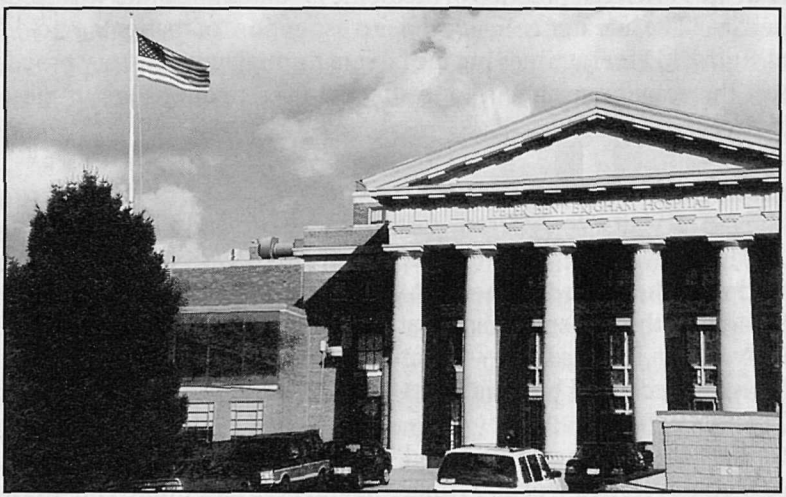
The catchment area for a country like Bangladesh is enormous even if it were a developed country. The approach needs to be simple yet effective. The use of simple educational messages on the treatment of diarrhoea is a case in point. As mentioned in the earlier report another programme to help with respiratory tract infection in infants is being adopted. Again simple messages are the most effective.

The American practice of medicine tries to ensure that there is a safety net to protect those most vulnerable. However it is sad to say that even in the developed world a lot of people are missed. In both environments it is important to educate the public about health care issues.

I think the message that I learnt from my elective is that patients' expectations of their doctors vary widely from nation to nation. The medical profession is largely guided by these expectations and may even be instrumental in forming them.

As doctors we need to learn to be adaptable. Medicine is constantly changing and whether we like it or not we need to change with it. Visiting different parts of the world allows one to adapt to their particular ways of doing things. I feel that this was an invaluable experience and thank all those who assisted me.

Alamgir Kabi



Letters

We would like to hear your views on any issues raised in any of the Gazettes, or anything to do with Guy's. You may have an opinion you would like to share with the rest of the readership. We would like to see some of your points published in future issues. If you feel you want to air your thoughts please write to the editor.

You are reminded that it is at the editor's discretion whether to publish a letter and that derogatory personal references to any individual will not be acceptable. We will however do our best to let you have a say.

An Interview with: Dr Mac Cochrane

What's a JCB?

To the majority, this is a simple enough question - the answer being a digger, but to those who have been a student on Dr Cochrane's firm, this question spells their impending doom during a ward round as the answer is that indeed a JCB is a digger, but one which they've used to dig a rather large hole for themselves by answering a question completely incorrectly - future students beware!

Mac Cochrane is currently consultant in respiratory medicine at Guy's and is the new Post-Graduate Dean for UMDS. He is also a keen researcher, particularly into asthma and compliance, and has published papers in several of the foremost journals, including 'Nature'.

He joined Guy's in 1963 as a medical student and was invited to undertake a physiology BSc following his 2nd MB. This involved many fields of physiology, including a respiratory module during which developed his interest in the field. After qualifying, he did both House Officer jobs at Guy's, the first of which was an incredibly busy post as 'renal transplant house surgeon' in which he had 10 nights off in 6 months but nevertheless served as an invaluable learning experience. After a SHO post in Deptford he was posted to the Brompton in the 'country branch', a very relaxed 3 months where he spent most of his time barbeque-ing and playing tennis as well as working for his membership. He continued at the Brompton carrying out research concerning deaths from asthma at the hospital which suffice to say did not please the Head of Department - he then decided to move on! Posts in Greenwich, St Olave's, New Cross, Hither Green and Lewisham followed, during which he was appointed a consultant post at the age of 32, and he returned to Guy's where he has remained ever since.

What made you choose medicine as a career?

I really don't know the answer to that one. I always said that I wanted to study medicine, maybe because at school I was no good at maths and so I did other science A-levels which then meant that I had to study biology, physics, and chemistry. I suppose then that medicine was really a choice of exclusion.

What are your best memories of student life at Guy's

My most memorable times were probably during my BSc year. One of the modules was gastroenterology and this involved each student having a nasogastric tube inserted down his/her throat each morning and the stomach contents aspirated. We soon found that this was an excellent cure for a hangover and we were even rewarded with a free breakfast every morning! The respiratory module was also very good as we were able to go to Farnborough to use the centrifugal machines and the deep sea diving bells to assess the effects of pressure and centrifuge on ventilation-perfusion ratios in the lung.

What does your job involve now?

Since becoming a consultant, I have had a number of careers as well as being a consultant chest physician. I was the University Representative for Greenwich District Health Authority in the early 1980s. This served as a great initiation into committee work as it was during the beginning of the hospital closing era. At the very first meeting that I attended, we were proposing the closure of the Seamans' hospital at Greenwich. Many sailors from the seamens' union had turned up and the discussion resulted in us being pelted with tomatoes and eggs and had to escape via the back windows. With the closure of more hospitals, several similar meetings ensued, one included us being covered in flour.

In 1985, I became deputy director of medicine at Guy's and worked closely with Professor Keen who was Director. He made my exposure to Hospital Management not only bearable but actually stimulating and fun. Following this, I became a Clinical Advisor, and later Senior clinical advisor, to the students and I also became involved with the appointment of the Senior House posts in the Trust. The next addition to my workload came in the late 1980s when I became an examiner for the University of London.

How did your new role as Post-Graduate Dean come about?

In early 1994 I was invited to apply for the job of Regional Associate Post-Graduate Dean, a secondment to look at ways to introduce the Calman Training Programme which is a scheme to improve the training for registrar and senior registrar posts. This was very enjoyable and in July '95, the Dean retired early and so I became acting-Dean. This was a very hectic 6 months which I only survived thanks to the support of my colleagues at the chest unit at Guy's. Following this, I applied for the post of Post-Graduate Dean at UMDS and was appointed in December '95.

Why did you apply for the post?

I have always been very interested in post-graduate education, initially on a less formal basis with my department's staff. Also, if you are fortunate enough to be appointed a consultant at a relatively early age, you need a regular alteration in career to maintain new challenges. This post is a natural development from my previous post-graduate posts and allows me stay UMDS-based, whereas before I was rushing all over the region. Being based at UMDS also enables me to continue my other interests such as research, teaching students, and clinics and I will be involved in post-graduate teaching from house officer to consultants in association with the Royal College.

What will your new role entail?

At the moment I'm still finding out myself so I'm not really sure! One new aspect that I have found is that there is a move to develop a Post-Graduate Dean purely for the basic sciences so hopefully, by working together, we will be able to develop better integration between basic scientists and Doctors, which is vital for both groups of graduates.

Will you be involved in improving/abolishing the sign-up system?

I remember the sign-up system as far back as my student days and it has been evolving since then, so in fact it is a constantly improving system. We must remember why the system is in place at all and this is because clinical medicine is essentially an apprenticeship and as such it is important to know whether a student has turned up, can take a history and examine a patient competently. These are skills which are difficult to assess but are ones that

clinicians are very good at measuring. About 18 months ago, we spent a great deal of time re-assessing the structure of the sign-ups and are constantly trying to improve their objectivity. We have since introduced criteria to measure what is 'good' attendance and what is 'acceptable' attendance for example. The MCQs stand as a good objective indicator for knowledge, particularly 'core' knowledge and even the clinician's impression, which is notoriously subjective, now has some degree of objectivity. Of course subjectivity is inherent in medicine as there are no set guidelines for what makes a good Doctor.

You also have to remember that the firm grades are not the only determinants of the sign-up as extra-curricular commitments are taken into account. Sign-ups are also a very good indicator of the students' pastoral care as a student who frequently has good sign-ups and then suddenly drop can indicate financial or emotional worries, for example, which can then hopefully be rectified by the clinical advisors.

One issue that is currently under debate is whether the less able students should be given campus house jobs and at present this is a highly contentious issue. It seems almost paradoxical that the less able student is expected to perform in an environment where there is far less support and training than would be provided in a campus setting. Some hospitals are now in fact beginning to approach this issue such as St George's by giving less able students house jobs.

You have been a Guy's examiner for several years and have recently stopped examining UMDS students, why is this?

UMDS has now moved out from University-based exams to school-based exams and as a senior clinical advisor, I feel that I know too much about the students to remain unbiased! I shall however remain a University examiner although I'm not really sure why anyone would want to be one. It is an extremely hectic period with scripts to be marked in a single weekend, the students having been trained sufficiently to develop illegible handwriting, followed the next week with four days of continuous examining, 9 am till 5 pm with 40 minutes off for lunch.

So, why did you choose this task?

You don't choose, you get 'asked'! In fact that's not entirely true as you are 'suggested' to apply by a senior collegue, a request that is not to be rejected! Of course the job does have some benefits, one of which is that the week before the exams, you have to brush up your own knowledge and this helps to keep you up to date. I'm fortunate in that the week before the exams, I have an annual meeting in America and so on my return flight, I read the latest textbook of medicine that I can get my hands on. I'm afraid I can't promote any one book in particular as authors include my friends and collegues so I don't wish to offend them! Examining also improves my teaching as I can see students' errors and improve my teaching to try to prevent these in future.

What do you see as the main faults of students during finals?

To be honest, I'm always very impressed by the students on a whole and it is only about 5% who are unsafe, mainly due to a lack of experience and failure to read around the subject. This is particularly evident in paediatric short-cases. At UMDS, our major strengths are in good presentations, which I hope will continue, as communication is the real hallmark of quality medicine.

What do you look for during examinations?

Confidence without arrogance is an important attribute coupled with evidence that the student is actually thinking about the case he/she is presenting rather than just presenting the history parrot-fashion. It is also important to think about the differential diagnoses without suddenly jumping for a weird and wonderful syndrome that the examiners haven't even seen themselves. So I suppose that evidence of logical and clear thinking is an important ability for a finals student to possess.

How much time do you have for clinical work and research?

I have two full clinics each week, two ward rounds and a general medicine take-in which I feel is a suitable amount considering the time that I have to allot to my other committments. My research has had to become very focused due to the time constraints. At present, in conjunction with a research psychiatrist and a clinical psychologist, I am investigating reasons for patients'

non-compliance in taking their medication and then trying to combat these problems.

What do you see as the most satisfying and frustrating aspects of your job?

I gained immense satisfaction in having a paper published in 'Nature' but generally, the most satisfying aspect of my job is that I have always had new opportunities and challenges throughout my career. Concerning the most frustrating aspect of my job, I suppose it is the constant paperwork which is ever increasing and merely seems to reduce the amount of time that should be spent on improving patient care.

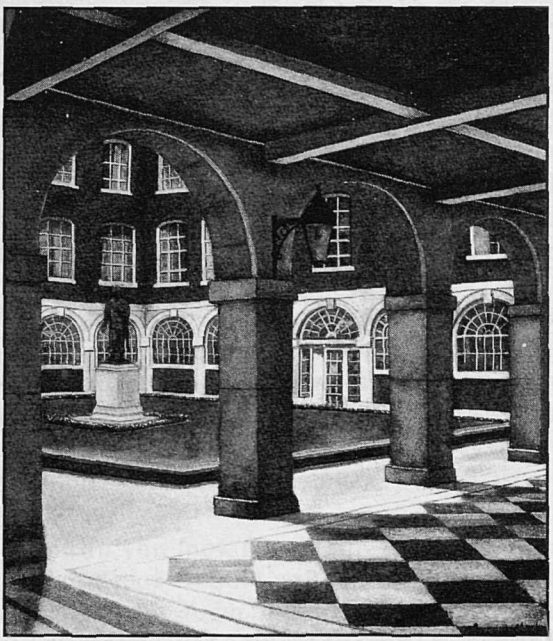
Could you describe a typical day?

I think the best thing about my day is that there is never a typical day. My favourite day, however, is probably on Thursdays when I have my ward round, clinic, chest meeting and student teaching - a busy day, but one that is varied and often highly entertaining.

Paul Hayden

Guy's Hospital MEMORABILIA

Unique items available only from the Gazette



These high quality cards depicting the Colonnade are left blank inside for your own message. The original oil painting by Clare Walford, a recent graduate, was presented to Dr Scott in appreciation of his 20 years as Gazette Committee Chairman. Cards are available in packs of 10.

Price £10 per pack of 10 + £1 p&p

To: The Manager
Guy's Hospital Gazette
Boland House
St Thomas' Street
London SE1 9RT

I enclose a cheque/PO for £ .....
NAME: .....
ADDRESS: .....
.....
.....

Please make cheques payable to Guy's Hospital Gazette

Office hours: Monday to Friday 1-5 pm. Personal callers welcome.

Lord Brock Memorial Essay Competition

Dr Bright's Disease

The following article is an excerpt from one of the entries in the 1995 Lord Brock Memorial Trust Historical Essay Competition. The essay was highly commended in the competition and as well as analysing the work of Richard Bright, one of Guy's best known physicians, who is remembered primarily for his work on renal disease, the essay demonstrates how significantly attitudes in medicine changed during the early Nineteenth Century.

Richard Bright was a man of his times. Born to a wealthy banking family in Bristol in 1789, he was educated locally and began his medical training at Edinburgh. This Scottish seat was the leading medical institution in the British Isles, able to compete with the hallowed institutions of Paris and Leyden, and attracted students from the United States as well as the most able from south of the boarder. He spent two years there, from 1808 - 1810, before he accompanied Sir George Mackenzie on a journey through Iceland. This trip is revealed in Mackenzie's 'Travels in Iceland' to which Bright added notes on botany and zoology. It was not the last time that Bright would travel extensively, for after spending two years 'walking the wards' at Guy's Hospital, and a further year at Edinburgh where he graduated in 1813, he travelled to Europe and detailed his experiences in his book 'Travels from Vienna'.

> ***'The works of Bright illustrate superbly the influence of Paris medicine, but also the limitations that were apparent and a certain link with the past that still remained with respect to therapeutics and to management.'***

'Walking the wards' in a London Hospital was de rigeur for any young hopeful physician, and it was at Guy's that Bright came under the influence of Astley Cooper. He attracted Bright to pathology and to the post mortem room, and it was during these two years that he learnt all that had been ushered in by Paris medicine; the need for physical examination, the need for anatomico-clinical correlation and the need for autopsies, (literally 'seeing with one's own eyes.') This was the sensualist philosophy of the French ideologues, who believed that knowledge came through experience with the senses, and not through mental reasoning. This influence was all pervasive, and it involved seeing at a macroscopic level, that is at a tissue and not at a cellular level. Seeing at a microscopic level was still not routinely feasible and the potential of the microscope was not fully utilised until nearer the end of the nineteenth century, by the physician Robert Koch. The works of Bright illustrate superbly the influence of Paris medicine, but also the limitations that were still apparent and a certain link with the past that still remained with respect to therapeutics and to management.

'Dropsy was a terrible disease, involving a constant struggle against the rising flood waters within one's body, which would be intermittently excluded in vast diuresis and through exudations through the skin.'

After returning from Hungary, in December 1816, Bright was elected a licentiate of the London College of Physicians, and he joined the London fever hospital as assistant physician. In 1820 he began a private practice in Bloomsbury Square, and was elected in the same year to Guy's Hospital as an assistant physician. It was now that he began his successful research in the post mortem room, where he toiled with great success. He was elected FRS in 1821, and in 1824 he was elected full physician to Guy's, lecturing courses on medicine, materia medica and botany.

Bright's work on renal diseases has brought him long lasting fame, although his interests were by no means confined to the kidneys. Indeed his first

publication in 1827 was 'Reports on Medical Cases' which at once made him famous, and which covered the whole gamut of bodily afflictions. Likewise, 'Elements of the Practice of Medicine' which he wrote with Thomas Addison in 1839, was not wholly concerned to the granulation of the kidney that this essay will focus on.

Richard Bright's writings on renal disease

The presenting symptoms of renal patients, who were not classified as such before the work of Bright, were dropsical. Dropsy was a terrible disease, involving a constant struggle against the rising flood waters within one's body, which would be intermittently excluded in vast diuresis and through exudations through the skin. 'Dropsy' was not associated with 'renal' or 'cardiac' disease, although the physician and nosologist, William Cullen made a passing association of the kidneys to the diseased urine out-put of his dropsical patients. He wrote in 1787 that 'This scarcity or urine may sometimes be owing to an obstruction of the kidney, but probably is occasioned by the watery parts of the blood running off into the cellular texture, and being thereby prevented from passing in the usual quantity.'

'Bright was thus one of the first, if not the very first, to define a chemical process that became diagnostic for a disease.'

Bright realised that certain dropsical patients had albumin in their urine which he detected by heating the patient's sample. Bright was thus one of the first, if not the very first, to define a chemical process that became diagnostic for a disease. To test for albumin, Bright heated the patient's sample and if albumin were present 'its insolubility in boiling water and dilute nitric acid' would lead to a cloudy precipitation which would indicate its presence.

In this way haematuria indicated renal disease, and the presence of blood could be seen as a tint to the urine. To distinguish blood from bile, Bright recommended the addition of nitric acid, which would lead to a red hue with bile, but to no change with blood. If the blood had separated, the supernatant should be decanted, which would contain the blood serum, and Bright de-

scribed how after the addition of nitric acid 'a turbidity ensues from the coagulation of albumin,' (albumin being a blood protein.) In this way Bright had formed the first practical laboratory test as an aid to diagnosis, a feat which could only have been performed in a hospital environment, and which in turn encouraged the growth of the pathology unit. Yet clinical analysis of the urine was not the only way that Bright understood renal disease.

By performing post mortems, Bright showed that all those patients who suffered from 'dropsy' and had coagulable urine, had striking changes in their kidneys. Bright revealed his findings in the first volume of 'Reports of medical Cases' in 1827, in which the first twenty four cases illustrate his discovery. he made illustrations of his findings and answered his critics in the following way; 'One question may be asked in this place - Do we always find lesions of the kidney as to bear us out in the belief of the peculiar condition of the urine, to which I have already referred and does this show us that the disease, call it what we may, is connected necessarily and essentially with the derangement of that organ? After ten years' attentive - though I must not say completely impartial - observation, I am ready to answer in the affimative.'

'Percussion and auscultation...were so much part of the new approach to medicine...'

In the description of his cases, Bright reveals his dependence on the macroscopic level of analysis propounded by the tissue theory of the young French physician Xavier Bichat. He writes that 'On cutting into the kidney .... specks are found distributed in a more or less regular manner throughout the whole cortical substance, no longer presenting a doubtful appearance, but most manifest to the eye.' Examples of reliance on the senses are abundant; 'The kidney is quite rough and scabous to the touch externally....the feel is hard....and the texture is found to be semicartilaginous in firmness.' Visual and tactile senses are both being employed.

Furthermore Bright showed how many of these dropsical patients suffered symptoms such as vomiting, headaches, pericarditis and seizures, which were later realised to be the symptoms of uraemia. Bright was successfully using

sight in the post mortem room (or as Michael Foucault termed it 'the gaze') to puzzle out a plethora of symptoms and to attribute them to one common origin of disease; the deranged kidney. He also fulfilled the sensualist philosophy by gaining knowledge though his external auditory meatus. Bright was clearly at home with examining his patients physically, and evidence of physical examination of the living is indeed ubiquitious. He wrote, 'On percussion, the chest appears quite resonant, except around the region of the heart and pericardium. By assistance of the stethoscope I thought the sound of the heart's beat was as if performed through fluid.' By using these two methods, of percussion and auscultation, which were so much part of the new approach to medicine, Bright was able to detect the pericardial rub which became part of his list of the indications of renal disease. Auditory, as well as visual and tactile senses were being used, and objective signs, detectable only by the physician, were becoming equally, if not more, important than the subjective symptoms experienced only by the patient, in forming a diagnosis. Bright implemented all that had been taught him in a way that led to a perfect conclusion, fulfilling all the potentials of sensualist learning, that the ideologues had promised.

'Clearly whilst Bright was a man of great innovative spirit, he was still a product of the Eighteenth Century.'

In 1842 Bright was given permission to assign a certain number of beds to renal patients only, for a period of clinical study. This was a forerunner of the 'metabolic ward' or 'clinical study unit' of the Twentieth Century. Yet despite the enormous insight that Bright had towards his research and his power for clear thought and analysis, he remained a physician of the early Nineteenth Century in his understanding of the new disease. His language on aetiology and treatment go back at least to Galen, if not to, the Hippocratic authors themselves.

Bright wrote that nephritis 'may be produced by general, or partial exposure to cold and damp' and that 'it most frequently occurs in the dispeptic or gouty and in persons of sedentary and luxurious habits' as well as 'in the highly

scrophulous.' This is typical of a humoural and holistic approach to medicine, that existed for centuries, where the patient's constitution and lifestyle are paramount factors in the diagnosis. Under the subheading of 'Prognosis' Bright comments that the outlook for the patient depends on their 'observance of a regulated diet and regimen' advice which reads as if straight out of the texts of the Hippocratics. Furthermore he recommends a 'bland but nutritious diet, gentle tonics and country air to endeavour to improve the general strength.' Clearly whilst Bright was a man of great innovative spirit, he was still a product of the Eighteenth Century.

Further reference to a holistic approach is found in 'Observation and Cases.' Bright writes about one of his patients; 'I enjoined upon him the greatest care in avoiding exposure to cold and chills; told him to clothe himself completely in flannel, to keep strictly to a milk diet, and to regulate his bowels with sacmonny or some simple purgative.' Clearly Bright still adhered to certain Galenic principles, but he also embraced the clinical approach of Paris Medicine. He was the first to see that dropsy was not a disease in itself, but that it was a symptom of another disease. Also his clear clinical approach to examination and history taking is apparent from the following example of case VIII;

'Bright accounted for changes in all the organs and viscera of his patients, and is incisive enough to see the involvement of the heart, which was later to become known as congestive heart failure.'

'Jerimiah Collins, aged 50, an Irishman, who had served seven years in the navy....tongue covered with a brown fur in the centre, white at the sides; pulse 88, rather sharp but compressible; urine slightly acid, of pale colour, coagulable and becoming very much like milk in appearance on the application of heat.'

What is more, Bright realised the possible role of the heart in producing the symptoms of dropsy. The constant appearance of granulated and shrunken kidneys had convinced Bright that failure of these organs was the root of the

problem of albuminous urine. He noted that all his patients with albumin in their urine, had diseased kidneys on post mortem examination, and that those without coagulable urine had undiseased kidneys. Yet Bright also noticed that 'It is observable that the hypertrophy of the heart, in some degree, to have kept pace with the advance of disease in the kidneys; for in by far the majority of cases where the muscular power of the heart has increased, the hardness and contraction of the kidney bespoke the probability of a long continuance of the disease.' Bright accounted for changes in all the organs and viscera of his patients, and was incisive enough to see the involvement of the heart, which was later to become known as congestive heart failure. Bright embodied both the old and the new, and was a man, along with physicians such as Astley Cooper, Thomas Addison (1783 - 1860) and Thomas Hodgkin (1798 - 1864) who built up the outstanding reputation that soon belonged to Guy's Hospital as a place of medical excellence and learning.

The naming of the disease

The naming of diseases is an interesting process. Bright had discovered a 'new' disease, and it was subsequently named after him, in the various forms of morbus Brightii, maladie de Bright, Bright's kidney or Bright's disease. Even before this, the condition had been variously labelled, as dropsy, nephritis and inflammation of the kidneys. Bright himself felt the vagueness of description, writing that 'the disease, call it what we may...' This ambiguity of terminology has continued, and a suitable name has not been forthcoming. Thomas Watson complained in 1844 that, 'For this disease we have no appropriate name. I wish we had. Some call it 'granular degeneration' of the kidney, but the epithet granular is not always applicable. Likewise the British physician S.J. Goodfellow, who wrote a small volume on Bright's disease in 1861, advised that 'A great, deal of thought and ingenuity have been built fruitlessly expended in discovering

'Bright had discovered a 'new' disease, and it was subsequently named after him, in the various forms of morbus Brightii, maladie de Bright, Bright's kidney or Bright's Disease.'

a name.....I would advise you to use that of Bright's Disease - an arbitrary term used for different affections of the kidney.'

The trouble with naming the disease stemmed from it having no one characterising morbid appearance. The choir of a doctor's name to call it by, demonstrated that the disease was no longer just the patient's, but also the doctor's. Diagnosis no longer dependent on the patient's subjective experience alone, but also on physical changes, such as a periodical rub or a heard pulse, morbid changes in the autopsied kidney and the secretion of albuminous urine, which were changes identifiable only by the doctor. It was a doctor's disease as well as the patient's; it was Doctor Bright's Disease.

Thomas Addis however, a leading researcher into renal disease, saw fit to title his second publication of 1948 'Glomerular Nephritis', dropping his title of 1931 'The Renal Lesion in Bright's Disease.' This was by now old-fashioned, and a new language of renal physiology was being built. During the 1940's the mathematical idea of clearance and glomerular filtration rates contributed to the new discipline of 'nephrology', and physiological terminology replaced structural and personal thinking.

'The trouble with naming the disease stemmed from it having no one characterising morbid appearance.'

The final stage in this bizarre name changing occurred in America in 1974. 'End Stage Renal Disease' or ESRD was defined as 'that stage of renal impariment and/or kidney transplantation to maintain life.' This was part of Public Law 92 - 603 which was a social security act to implement and to manage financial support of American dialysis patients. ESRD is a disease of entitlement, and is a label with little significance to either the patient or the doctor. Bestowed by government, it has meaning purely to the bureaucrat.

A final change in the condition so ably defined by Richard Bright is that sufferers of ESRD (or renal disease) are now described as 'dialysis patients.' i.e. the treatment has become the disease. Sufferers do not usually call

themselves renal patients, or complain of overwhelming oedema and fluctuating uraemia, but instead suffer the symptoms of dialysis. Clearly both the experience and the understanding of the condition which was once known as dropsy has changed enormously in two centuries. Yet Richard Bright, working at Guy's Hospital, was the man who applied all the philosophy of the Paris medical schools and of the great English thinker John Locke, and brought it to a successful practical conclusion. He altered the understanding of a disease for doctors, and it has since been altered for the understanding of patients.

Hannah Lord

NEW SUBSCRIBER
BANKERS ORDER SUBSCRIPTION FORM

Photocopies are acceptable

Please return completed form to:

Guy's Gazette
Boland House
Guy's Hospital
St Thomas' Street
London SE1 9RT
Tel 0171 955 5000 ext 5413/5414

To the Manager

_____ Bank plc

_____ Branch

_____ Address

_____

Please pay the sum of £15.00 annually on _____ commencing 19____ to the credit of:

Guy's Hospital Gazette
Account No. 80401269
Midland Bank plc
Southwark Branch
28 Borough High Street
London SE1 1YB

and debit my account accordingly:

Name (please print) _____

Account No. _____

Address _____

_____

Signature _____ **Date** _____

Problem-based Psychiatry

A newer type of book that draws attention to the point that the older style of medical textbooks are for didactic, inflexible fact based learning and as the medical curriculum is changing, moving away from fact to problem-based type learning so should the type of books we use. The new approach seems to be to induce the medical student to do some critical thinking of their own, something many of us find quite a feat.

Having completed a Psychology BSc I thought that most medical undergraduate psychiatry books would be very much on par with each other, but after reading this one I was impressed. The first thing that is of great pleasure to most medical students is to find a book of limited thickness and this book fits the bill- a mere 170 pages.

Each chapter starts with its own individual contents page mapping the chapter itself making it very easy to find your way around the book. An introduction or specific definition is usually followed by short case histories. Based on these various case histories questions are asked and explanatory answers are given. This is meant to be comparable to a group tutorial or clinical situation where answers to questions can be thought out and discussed, thus allowing the reader to gain knowledge on how to deal with specific cases rather than learning fact after fact and in this respect, the book succeeds. At the end of each chapter are a couple of highlighted areas reviewing the key points of the chapter, followed by a small Self assessment test containing MCQs and short answer questions. Further reading and references and also given.

This book is great for those who enjoy problem based learning style. It is interesting and very easy to read and light enough to carry around in your bag without feeling weighed down, but for those of you who like just 'fact after fact', then you may be advised to look elsewhere. (Problem-based Psychiatry, Green, Churchill Livingstone £15.00 ISBN 0443051984)

Kate Mundra

Statistics in Small Doses

This book takes an unusual approach to the teaching of statistics with the bulk of each chapter consisting of a series of short questions. The right-hand side of the page reveals the answers, which should remain covered up by the reader until questions have at least been attempted. Each chapter ends with a

brief summary which succinctly explains the material covered.

However, many students coming to statistics for the first time may dislike this order of presentation and in addition, the plentiful use of mathematical notation will not suit less numerate students. There is also an emphasis on tests of significance, rather than the use of confidence intervals.

Not withstanding my previous comments, however, it should form a valuable revision aid and it would certainly be useful for use in the library.

(Statistics in small doses, 3rd edition, Castle & North, Churchill Livingstone, ISBN 0443045429, £10.95)

Nigel Smeeton

Pharmacology

The long awaited 3rd edition of this book appears to encompass helpful and necessary changes and extensions to the text, not to mention the addition of our very own Professor Ritter as a third author, which brings a clinical touch to the book.

The authors have stated their aims quite clearly in the preface, highlighting new chapters whilst reiterating those aspects of the book which were new features in the second edition. It seems, at a glance, that the 3rd edition is much more geared towards the application of pharmacological knowledge as well as towards growing concerns in the medical world - for instance, an inclusion of HIV infection and possible treatment in the Anti-viral drug chapter. Another change which seems particularly apt is the collection of the neurodegenerative disorders into one new chapter as opposed to the information on each disorder being scattered around the book as in the 2nd edition.

Notably also are the modifications to all the chapters with respect to the clinical aspect of drug therapy. Throughout the text, pink boxes appear crammed with information concerning the main indications for drugs, side effects, advantages and disadvantages, including emphasis on the popular drugs and their alternative uses. These boxes are exactly what is required to consolidate information.

Of course, as in the previous edition, key points are summarised in red boxes at intervals throughout each chapter. These are particularly useful for picking out relevant parts or simply when time is of the essence and speedy knowledge retrieval is required.

The varying depths to which Rang, Dale & Ritter can be used means that it is useful at any stage of Medical School education. For example, at 1st & 2nd MB level, those who wish to excel in their studies should find it apt and it is invaluable to anyone having to write occasional essays.

I would also recommend extensive usage of the book for an Intercalated Pharmacology BSc - it provides an excellent base which can be built upon by following up the extended list of references at the end of each chapter.

Overall, Pharmacology proves to be a well rounded book which can be used in as much depth as is desired.

(Pharmacology, Rang, Dale & Ritter Churchill Livingstone ISBN 0443050473).

Susan Jain

407 Art Club Spring Exhibition

March 18 - 22 1996

An exhibition of original work will be held in the studion on the 4th floor of Hunts House. Any student, staff or associate of the Medical School and Hospital who would like to contribute paintings, drawings, or other original work should contact Dr T Gibson, Ground Floor Shepherds House, tel. 0171 955 4310 or fax 0171 407 7532

A new approach to practice?

I was saddened to hear that after this year there will be no more nurses receiving a Guy's badge. Along with my mother and two sisters, I shall return to Guy's in May to mark this end of an era. Following Mr Cobell's article in the November issue, my sadness deepened and so I thought that I would respond with some positive comments for nurses to contemplate.

1. The UKCC recognises the accountability of the professional nurse and midwife and supports the advice given in areas where the nurse or midwife has achieved competence.

2. Complementary practitioners would welcome research funding, and nurses are conducting their own trials in aromatherapy in areas such as intensive care, geriatrics and learning disabilities. Midwives are researching homeopathic preparations of Arnica for perineal trauma in postnatal women.

3. There is an abundance of evidence published in medical journals and elsewhere as to the effectiveness of homeopathy. Research includes results in biochemical, botanical, zoological work and investigations using physics.

4. The BMA felt it necessary to publish a report in 1993 'Complementary medicine - a new approach to practice' not out of 'politeness' as Mr Cobell wrote but hopefully out of regard for the high percentage of patients who chose to consult alternative practitioners. It is likely that patients consider alternatives because their expectation of results from mainstream medicine does not transpire. This need not be ridiculed but investigated particularly for outcomes.

5. Registered and qualified practitioners are insured to protect the public and do have a code of ethics.

6. The Faculty of Homeopathy is authorised by Act of Parliament to train doctors in homeopathic medicine: homeopathy has been available on the NHS since 1948, and now so is osteopathy.

7. The NHS reforms are encouraging GP's to offer additional therapies and the Government would save money especially on drugs eg. night sedation.

8. Nurses and midwives are in an ideal position of accountability to fulfil this role, and with further training can offer choice for patients who request alternative approach to care.

9. A joint report published by the Royal College of Physicians and the Royal College of Psychiatrists claimed that 50% of all illness may be due to anxiety and stress. If nursing care can alleviate anxiety and stress; if complementary medicine can; if therapies such as hypnotherapy can then is not prevention better than cure?

The World Health Organisation has given respect to The Research Council for Complementary Medicine, and links have been forged also with the BMA, and the MRC.

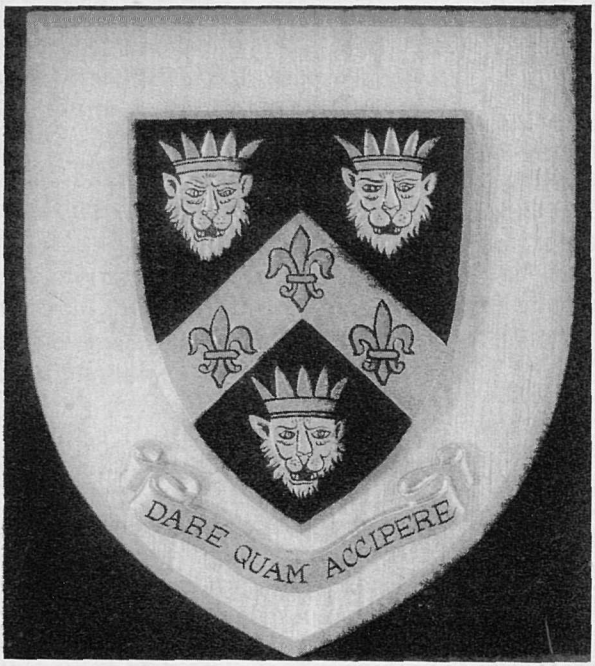
For the nurses and midwives wanting to become informed, skilled and accountable in their provision of complementary therapies in practice, Mr Cobell says 'beware alternatives' but I say 'be aware'; the UKCC legislation and codes of practice is about enabling the nurse or midwife rather than limiting practice and allows for safe development of the profession to meet the needs of the patient.

Parts of my Guy's Finals was to conduct a 15,000 word research project, so I know that Guy's nurses are capable of making informed decisions about the care that they offer, and I wish them well.

Bridget Cummings SRN, RM

Guy's Hospital MEMORABILIA

Unique items available only from the Gazette



Hand painted Guy's crests mounted on a selection of woods. These make ideal gifts for any Guy's man or woman. Just what you need to decorate your surgery or study!

Price £22 each + £1 p&p

To: The Manager
Guy's Hospital Gazette
Boland House
St Thomas' Street
London SE1 9RT

I enclose a cheque/PO for £ .....
NAME: .....
ADDRESS: .....
.....
.....

Please make cheques payable to Guy's Hospital Gazette

Office hours: Monday to Friday 1-5 pm. Personal callers welcome.

David John Lipscomb

Dr David Liscomb died on October 30th after a short illness. He was just 51. A week later, his friends and colleagues packed St Andrew's Church, Sherborne St John to say our last farewells.

As autumn sunshine suffused these ancient walls, we reflected on the shock of suddenly losing so young a man. We thought about the enormous contribution he made to the life of the North Hampshire Hospital and of his fifteen years of distinguished service as Consultant Chest Physician. Trained at Guy's and moving swiftly up the ladder to Addenbrooke's Hospital, Cambridge, David was appointed to our hospital in 1980, being elected a Fellow of the Royal College of Physicians in 1988. Many thousands of local people will be grateful for his professional skill and sensitivity. A generation of doctors in training have gained from his clear teaching. He was an exceptionally good doctor. We recalled how fit and healthy David had always been, living every moment, whether in his work, playing golf, organising a cricket match or out racing his beloved keelboat, as he did just two weeks before he died. How we loved him for his open nature, his energy and the way he enjoyed everything he did. How we shall miss his wise counsel and generous friendship. We remembered how, at the end of his life, knowing what was to come, he faced it with a courage rarely witnessed. We knew too how David had centred his life upon his wife Isobel and their three young daughters. We came to grieve with them and to offer our heartfelt love and sympathy. And as we filed out into the sunshine, we knew he was at peace.

Richard Cracklan.

Herbert Hugh Brown

Herbert Hugh Brown LDS RCS Eng died on December 31st 1995 at his home in New Alresford, Hampshire.

He qualified in 1940 and subsequently joined the Royal Navy as dental officer aboard HMS Mauritius, service which included action on D Day off Sword Beach. His hobbies were painting, motoring, travel and tending his own vineyard. He enjoyed 55 years in dental practice, was always proud of being a 'Guy's man', and will be much missed by his own family and his wider family of patients.

James Gourley Allardice

Dr James G Allardice MBBS (London) FRCS (Canada), a noted obstetrician and gynaecologist in Winnipeg, Manitoba, Canada, died suddenly, aged 62, in Winnipeg on January 6th 1996.

Jim was born in Kilmarnock, Scotland in 1933. He attended Epsom College and studied medicine at Guy's. After qualifying in1959 and pre-registration house jobs at St Olave's and Mile End Hospitals, he joined the RAMC for four years where he practised Obstetrics and Gynaecology. In 1964 Jim and his family emigrated to Canada where he was in general practice in Weyburn, Saskatchewan and Stanley, North Dakota, USA before settling in Winnipeg in 1968.

Jim then proceeded through the residency programme in Obstetrics and Gynaecology at the University of Manitoba, receiving his fellowship in 1971. He worked in private practice until 1986 when he joined the University of Manitoba Department of Obstetrics and Gynaecology as an Assistant Professor and Head of Clinical Obstetrics for the University of Manitoba and the Womens' Hospital in Winnipeg. One estimate is that Jim delivered 10,000 babies.

Many of his patients were aboriginals who came from the remote northern areas of Manitoba and from the Northwest Territories. His vast and mature experience was not only appreciated by his patients but also by the interns, residents, and nursing students whom he taught, as well as by his many collegues who turned up for advice and help with obstetrical problems. In addition, Jim helped start the Midwifery programme for Manitoba, the Family Birthing Unit at the Womens' Hospital, and the Memorial Crypt for the grieving parents of stillborn children and neonatal deaths. He was also Chair of the Perinatal and Maternal Welfare Committee of the College of Physicians and Surgeons of Manitoba.

Jim was particularly pleased when he received, in 1992, the 'Excellence in Teaching' Award from the American Association of Professors of Gynaecology and Obstetrics.

Apart from his family, Jim had many other interests outside medicine including boxing, sailing, skiing, squash, photography, bird watching, wine and bread making, and as an amateur handyman at his weekend cottage where his skills met with a varied amount of success.

He leaves behind him the legacy of a dedicated physician who will be sorely missed by his many patients and collegues. Our sympathy goes to his wife, Val, their three children, and their families.

Anthony S Valentine

Alan Holmes

Holmes Alan LDS RCS. Qualified at Guy's 1961. He was killed in a tragic road accident on 20th December 1995. He leaves his widow Colleen, his daughter Caroline and his son Simon (who qualified at Guy's as a dentist and doctor).

Lord McColl

The Lord Brock Memorial Trust Historical Essay Competition 1996

The Lord Brock Memorial Trust, which is responsible for the old St Thomas' Operating Theatre and Museum in St Thomas' Street opposite Guy's Hospital, holds an annual competition for a historical essay on a medical subject. Any medical historical subject can be chosen, but there should preferably be some connection with Guy's Hospital, St Thomas' Hospital, or the Medical School.

The prize is £300
The competition is open to anyone associated with Guy's, St Thomas' or UMDS.
The closing date is 31st August, 1996

For further written details, please contact Anne Rigby in the Special Trustees' office on Guy's extension 5316 or on 0171 955 4996.

Rugby

Guys's 1st XV v Alton
Saturday 13th January 1996 HOP

On a chilly January day at Honor Oak Park Guy's entertained Alton who were three places above them in the league and who were coached by Alistair McHarg the ex Scottish international player.

Last year at Alton Guy's suffered a heavy defeat by 36 points to 12. Alton are traditionally a large side and this year was no exception. The game started at a cracking pace and from the very first line-out Guy's were penalised for off-side in a line-out and Alton converted the resultant penalty. All the early line-out balls went Alton's way but the Guy's pack, though much smaller, were able not only to hold their own but to push the Alton pack in a very satisfactory way. Guy's went ahead with a fine try when Neil Davies kicked long, the ball was missed by the opposition full back and hacked through by their wing straight into the arms of Mark Jenkins who rocketed over for a try converted by Neil Davies. Guy's then began to get some ball from their own line-outs, scoring the short ball and continued to press their much heavier side back in the tight. Guy's went further ahead with a magnificent try by Ugo Ekeowa who, capturing the ball in the deep, deceived at least four Alton defenders with his swerves and went over in the corner for a try magnificently converted by Davies. A third try followed when Murphy managed to rob the Alton forwards of the ball and race up to the touch line where Dinsmore was on hand to score. Alton began to return to their traditional style of play revolving around their eight forwards in rolling mauls and this paid off for them when from a penalty five yards out from the Guy's line they trundled over for a converted try to take the score to 22-10.

The second half was more even in terms of possession. Guy's went further ahead when a short arm tackle nearly took the head off our outside centre and Neil Davies kicked the resultant penalty. The commitment of the Guy's side was very encouraging to see with the first Cup match against Barts and the London only a few days away. Guy's were securing a good deal of the ball in the loose and the forwards were playing very well as a unit, though the Alton mauls continued to be difficult to defend against. Guy's went further ahead when another fine run by Ugo Ekeowa on the left wing was stopped short of the line and when Billy Challacombe almost crashed over, Dinsmore was on hand to score. Ugo Ekeowa put the cap on a marvellous display when he scored Guy's fifth try with another fine run up the left wing to score racing in from about the half way line. Alton hit back with a penalty try to take the score to 35 points to 17. However, what seems like a healthy

difference in the scores was turned into a nail-biting finish when Guy's lost Barrio with an injured foot and Breeze came to replace him. Suddenly the extra weight of the Alton forwards began to tell as Alton changed their tactic to create kicks down the field. This resulted in two more scores the second being another penalty try to bring the score to a nail-biting 35-29 score with Guy's desperately hanging on for the final few minutes, having seemed unassailable earlier. There will be one or two changes for the Hospitals' Cup match, but overall this was a very good team performance, particularly in the forwards, where Dinsmore is beginning to show his class, the front row who were solid throughout and in the second row where the power generated in the scrums was impressive until Barrio departed injured. In the backs Neil Davies, as we have become accustomed, put in some magnificently long kicks, though he missed a few pots at goal, and Jenkins in the centre had an extremely good game. Team: Hostert, Finbar, D Baladasaran, B Challacombe (capt.) E Barrio, J Dinsmore, G Ryan, A Jeffries, J Murphy, N Davies, G Bevan, N Jenkins, A Jones, E Ekeowa, G Lawson. Scorers: tries, Dinsmore 2, Ekeowa 2, Jenkins 1, penalties, Davies 2, conversions, Davies 2.

SJC

Courage League
London SW3

Whilst Old Walcountians have one of the better hockey pitches in the South of London, they probably have one of the worst surfaces to play rugby on, although this has improved over the last 3 years. Guy's renewed their annual confrontations with Old Walcountians on a cold January day, mercifully dry after a wet night, having won three and lost four matches since the leagues began.

League games on the first Saturday of the New Year are rather unkind to universities and hospitals whose terms do not start until later. Perhaps that is why so few university sides are playing in the Courage leagues. Guy's were therefore showing one or two changes in the side, notably the pack, but from the start were very comfortable in the scrums and the line out where Rupert was winning a considerable amount of ball. Both sides were trying to play rugby in spite of the conditions, but the Guy's domination of possession in the first twenty minutes allowed the game to be played at the Walcountians end of the park but without being able to turn this opportunity into points. However, two tries were scored in quick succession. The first was a short penalty move when Johny C eventually crashed over after Baladasaran had been held up just short of the line. This was converted by

Neil Davies. The second try was a beauty. Guy's won possession from the loose and stormed off up the field from their own 22, the ball passing through forwards and backs alike down the left hand side of the field and eventually John Davies was over the line for an unconverted try.

The second half was rather dour rugby and lightened by an almost identical try for Guy's and for Johny C as the first try when he crashed over near the post from another short penalty move. The try was converted by Davies to take Guy's to a 19-0 lead. This looked uncomfortable, but Old Walcountians quickly came back with two scores. On the first of these, Guy's successfully defended a whole series of short penalties to the opposition within 5 yards of the line. They eventually succumbed. The penalty to Walcountians shortly afterwards brought the score to 19-8. The final quarter of the game was extremely competitive with possession keenly fought. A final try in the corner was scored by Rupert C after he had charged down an attempted clearance by the opposition full back and exchanged passes with Neil Davies. This was a good performance by Guy's. The scrumming and line-out play was excellent throughout with Rupert C outstanding in the middle of the line-out winning a considerable amount of ball. Richard Clinton playing his first game for the Ist XV looked very comfortable at tight head and on occasion the Guy's pack were able to push the opposition back for some yards and put their backs under pressure. Although there was great commitment in the loose, the opposition flankers were allowed too often to come into mauls from an offside position and steal Guy's ball without being reminded that this was against the rules of the game. For Guy's, Billy Challacombe played a Captain's game leading from the front, thought guilty on one occasion of yielding to the temptation of going for the line rather than passing to unmarked men outside him. He was supported by Johny C in the back row and usually P Davis. The pressure of the Guy's forwards allowed the defensive skills of the back division to be shown to the full, and Jenkins and Jones in the centre were, as always, utterly reliable in defence. Guy's now appear to be safe from relegation with a middle of the table position, but unlikely to get promotion. Team: L Hostert, Findbar, D Baladasaran, B Challacombe (capt), R Cocks, P, Davis, J Cocks, J Davies, N Davies, G Lawton, A Jones, G Jenkins, G Bevan, M Rose.

SJC

Hospitals' Cup Match,
Guy's V Barts & London
Chislehurst (1st Round)
17th January 1996

Cup matches are always special. This year Guy's found themselves in the first round against the new

combined Barts and The London side.

These games are always full of wit and passion and this game was no exception. A fair sized crowd had been persuaded to take leave of their hospital and School duties and had managed to find an unusually and sunny day for the match, that is unusual for a Hospital's Cup match, which traditionally are played in sleet, rain and mud. The early exchanges were fierce with no quarter asked or given. After ten minutes both sides had had replacements. James Dinsmore went off and was replaced by Angus Jeffries. The first score, however, came to Guy's when, after an elaborate dummy with all the back line bar two going to the left, the ball was passed to Breeze who scampered over in the corner for an unconverted try. The London were a much bigger pack with a good line-out technique and were winning most of the line-out ball. This meant that the right tactics were for Guy's to keep it in hand, though it took a little while for them to realise this. Barts/London missed a couple of penalties before Guy's scored again with a penalty by Davies given for a short tackle. The second try was impressive when, after a break by Ekeowa on the wing the ball was taken on by Jones and Angus Jeffries was well up in support to score and the try was converted by Davies. This left the score at half-time at 15-0. Guy's began to turn it on in the second half and the forwards played more cohesively. Guy's had one long rolling maul taking the ball down the left side of the field and from the resultant scrum Guy's went for a pushover allowing Murphy to pick up, and score. During this very good play, Guy's scored again via Pete Davis where after good combination work from forwards and backs alike he got the ball within 10 yards of the line and there was no way he was going to be stopped. At this point the referee showed he was rather sympathetic to what apparently was the lost London cause, and after a series of penalties awarded to London/Barts, a penalty try was rather mysteriously given. This was soon followed by another unconverted try to take the score to a less healthy 27-15. The latter was scored after a high up-and-under was claimed by the number 8 rather than the full back and the opposition crashed over to score. However, Guy's hit back immediately through a try by the captain finding himself in the centre and selling and outrageous dummy to score after loose ball had been secured. This took the score to a much more satisfactory 34 points to 17. However, Guy's generosity knows no bounds and although the game looked won, Guy's were attempting to run the ball from their own 22 and give Ugo Ekeowa the chance of a score but instead passed directly to the opposition centre who, grateful for the only pass he had all afternoon, scored in the corner. In spite of this, the game finished at a very satisfactory 34-22 points win to Guy's. This was

another fine performance by the Guy's side with the team looking cohesive and dangerous in the backs and the forwards playing very well together as a unit. They were able to apply pressure in the tight and their rucking and mauling was excellent and never allowed the opposition to settle down to a pattern. The line-outs will remain a problem which is unlikely to be solved until two freshers of 6' 4" or over are selected to the School. For Guy's, Davis played a storming game which included looking after other members of the team when they are in trouble in a protective way. Neil Davies showed once again what a great pair of hands he has and was the lynch pin of the Guy's attacks. Team: Baladasaran D, O'Sullivan F, Hostert L, Barrio E, Challacombe B (capt), Ryan G, Davis P, Dinsmore J (replacement), Jeffries A, Murphy J, Davies N, Ekeowa U, Jenkins M, Jones A, Breeze R, Rose M. Scorers, tries: Breeze, Davies, Challacombe, Murphy, Jeffries; conversions Davis 3, penalty Davies.

SJC

Womens' Football

Royal Holloway and Bedford WFC v UMDS WFC
ULU League: 21st January 1996
WON 1-0

The womens' football team travelled away to Royal Holloway determined to revenge a 4-3 defeat inflicted on them earlier in the season.

The bitterly cold weather ensured that the Guy's team only emerged from the warmth of the changing room minutes before the kick-off. This, however, did not stop the team attacking the Royal Holloway goal straight from the start. Both Caroline Child and Susan Jain came close to scoring with close range efforts as did Anna Maw who just shot wide with a superb long range screamer. Guy's kept this pressure up throughout most of the first half with Royal Holloway only threatening the Guy's goal on two occasions, one of them producing a reflex stop from Sally Hobson, the Guy's keeper. Despite the territorial and possessional advantage that Guy's enjoyed in the first half the score remained 0-0 come the half time whistle.

With Guy's having to run up the slope in the second half, it promised to be a tough 35 minutes. However, the superior fitness of the Guy's team and their hunger for the win enabled them to keep up their siege on the Holloway

goal. Emily Champ and Felicity Llewellyn were always dangerous up the left flank bringing off delicate '1-2's' and opening up the Holloway defence with great through balls. When Holloway did threaten they were thwarted by well timed tackles from both Su Kyan and Jane Shackel and if ever the ball was played through the centre of the Guy's defence, Tanya Burton, playing as sweeper, was always there to defuse the danger.

One of the most encouraging aspects of the game was the way in which the Guy's fullbacks Carol and Su attacked down the wings providing extra support to the Guy's front line. It was one such run by Carol James up the left wing which gave Felicity the chance to deliver a pin-point cross which Caroline, the centre forward, gratefully dispatched into the back of the Holloway goal. With Guy's 1-0 up, they never looked back. A jinking run by Angana Sahu forced a sloppy challenge by one of the Holloway defenders forcing the referee to award a penalty. Unfortunately, from the penalty spot the ball was shot over the crossbar, but with the final whistle blown a few minutes later, it was of no consequence.

This match was an enjoyment to watch (even more for Guy's winning) and both sides deserve warm congratulations for putting on a show full of skill and excitement.

Team: Sally Hobson, Tanya Burton, Carol James, Jane Shackel, Su Kyan, Emily Champ, Anna Maw, Angana Sahu, Felicity Llewellyn, Caroline Child (Captain), Susan Jain

JRD

Rowing

Boston Marathon

RESULT: Fastest Mens VIII

This year, as in years past, UMDS were drawn to this outrageous annual show of machismo, stupidity, and sheer bloody-mindedness, the mens first VIII deciding to enter the race seriously, and set a fast time (!?). As usual, we spent the Saturday night with Vice-President Fred Moorhouse and his family, who fed and watered us most generously upon our arrival.

Next day, we arrived in good time at the start in Lincoln. Despite needing to fetch our captain from Boston, (he'd driven up from a party in Bristol, that morning!) we were able to boat on time, and set off towards the finishing line, 31 miles away.

One part of the race involves carrying the boat around Bardney lock, and we reached this in a good time of 45 mins. Setting off once again, our cox allowed us very strictly controlled rest periods (60secs per hour) during which

food and drink was consumed. We rowed along smoothly and efficiently, at a comfortable 26 for the majority of the race. About half way, we took advantage of our new cox-box amplification system (wired up to a walkman), and so periodically rowed with some excellent music (I really can recommend this in a boat!!). This, together with our Viking helmets, provided some light relief whilst passing the miles, and earned many a comment from fishermen and other crews. Despite the frivolity of our crew, we were mindful of the fact that the fastest time ever from our club was set about twenty years ago, at 3.40:40, by our current President. The last couple of miles saw stern pair taking up the rating gradually, until for the last mile or so, we were rolling along at an incredible 36. Whilst being rather stupid (!) on the face of it, it's purpose was well served, as we finished in 3h 40m 28secs, the fastest time a crew from UMDS has ever set, despite the brisk headwind. This was the fastest VIII of the day; we were third overall, being beaten by the senior open coxless IV and octuple winners. Overall, the whole crew were well pleased with this achievement, and it rounded off a highly successful summer.

S Arnold

Cambridge Winter Head

RESULT:
Won, Womens Student IVs
Third, Mens Student VIIIs

An impromptu decision was made in November to visit Cambridge and give the whole club an opportunity to measure itself against opposition from the Cambridge colleges. This was to be the first race (and the first tour) for our enthusiastic freshers, and on the big day they perfomed well, both mens and womens crews finishing around mid-table in beginners groups containing about 30 boats.

Cambridge was also the first race of the year for the womens senior squad, and they were looking to do well against some of their college opposition. Indeed, they did so well that they won their category of senior student IV+ by an impressive 25 seconds, beating such crews as Magdalen, Loughborough and Birmingham Universities along the way. Unfortunately, they couldn't reproduce winning form in their VIIIs race, held shortly after racing in the four.

The mens first squad were eager to get to grips with some of the 'oppo' that might turn up at Henley's Temple Challenge Cup next year. The first VIII had a fast row, rating around 36 for the course, and were happy to finish 8th overall, (3rd in our category of 20) scalping some good colleges such as Pembroke, Trinity Hall, Queens, Magdalene (Camb. & Oxf.), and Trinity (Oxf.) in doing so. Our second boat had a good row; the new stroke setting a brisk but even pace, and they were heartened to finish in a time of 10 minutes dead, but their lack of practice together before the race meant that, inevitably, they did not challenge for honours.

The post - race 'wind down' as usual consisted of visits to the local watering holes, and (between the entire club) most of the college bars before all meeting up again at the infamous Curry Centre for the evening meal! Partying continued into the night, before a bleary eyed start back to London next day.

S Arnold

Practice for sale

Swindon, Wiltshire

A busy, well established practice plus a substantial family home, in good decorative order, close to the town centre yet with adjacent parking for patients, comes to the market as the vendor wishes to retire.

The equipment and surgery are ready for extensive modernization, but the current patient base produces gross figures of £72 000 and the expansion possibilities are exciting in the extreme.

The property is spread over four floors, with a rear garden and three garages. For details, contact:

W Martyn Boyle
Clyde House
42 Bath House
Swindon
Wiltshire
(01793 523076)

Biennial Dinner

The next Guy's Hospital Biennial Dinner will be held on Friday 4th October 1996 at the Connaught Rooms, London W1

The Dinner is open to all graduates of Guy's Hospital Medical and Dental Schools and all graduates of UMDS. It is hoped that as many people as possible will attend on this occasion.

There will be no increase in the price of the dinner, which is £40, and would those interested in obtaining tickets please contact: Barbara Ingarfield at Guy's Hospital on tel. 0171-955-4169 or fax 0171-955-4824.

As on the previous occasion, the seating will be on a round table basis and we are anxious to encourage the formation of as many parties as possible.

Martin Jourdan
Honorary Secretary

Changing Your Address?

Please give us SIX WEEKS' NOTICE of your move. This will help us to make sure your *Gazettes* continue to reach you.

PRINT YOUR NAME AND **OLD** ADDRESS	NAME
	OLD ADDRESS
	POSTCODE
THEN PRINT YOUR NAME AND **NEW** ADDRESS HERE	NAME
	NEW ADDRESS
	POSTCODE

Now cut out this coupon and send to:

Guy's Hospital Gazette
Boland House
Guy's Hospital
London Bridge
London SE1 9RT

FOR ALL GUY'S MEN & WOMEN

* * *

TO COMPLETE THE GUY'S NURSES' LEAGUE DAY OF CELEBRATION & TO MARK THE END OF AN ERA

A GRAND GALA RECEPTION

WILL BE HELD IN THE COLONNADE

on Saturday 11th May 1996

from 7.30 pm - midnight

The Colonnade will be heated, decorated and lit with chandeliers for an evening of music and dancing, with buffet and bars. Come and meet the friends of your Guy's days for a gala evening together.

TICKETS £40 EACH

* * *

Applications for tickets together with s.a.e. (6"x4" min) to:-GALA Sec., Guy's Hospital Nurses' League, Henrietta Raphael Nurses' Home, Guy's Hospital, St Thomas' Street, London SE1 9RT

Cheques payable to: GUY'S GALA ACCOUNT

GUY'S

HOSPITAL GAZETTE

April 1996

- Guy's Hospital Staff Round Report
- Interview with Dr Gransden
- Sir William Osler

CONTENTS

98 Passim
100Letters—Second rate hospital?
101News—Hallett Prize, Silver Service
104Feature—Guy's Hospital Staff Round
112Feature—Lord Brock Prize Essay
120Feature—Interview—Dr Gransden
130Reviews—MCQs in Anatomy, Anaesthesia
134Nursing Notes—The Day I Met Yvonne Moores
136Obituaries—Terence Finnegan, Norman Mayson
137Sport—Rugby, Boat Club
143Classifieds

Guy's Gazette

Editor Rikin Trivedi **Assistant Editor** Paul Hayden **Sub Editor** Sue Ferguson **Features Editor** Kate Mundray **Review Editor** Susan Jain **Sports Editor** John Davies **Nursing Notes** Denis Cobell **Office Manager** Margaret Flanders.
Acknowledgement Dean Flanders.

The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

Volume 110 Number 2455 April 1996
ISSN 0017–5870

Guy's Gazette, Boland House, Guy's Hospital, London SE1 9RT. Tel (0171) 955 5000 ext 5413. All rights reserved.

Printed by Hobbs the Printers Ltd, Brunel Road, Totton, Hampshire SO40 3YS

Passim

With only a few weeks having passed since the tragedy at Dunblane, the nations mourning has been curtailed by the latest episode of turbulence to hit the country.

Rarely has public outcry been so powerful as to dictate government policy, but such is the case following the most recent development in the Bovine spongiform encephalopathy (BSE) saga and its relation to the human form of the disease Creutzfeld-Jacob disease (CJD). The revelation that BSE may be transmissible to humans and that this may be the cause of CJD has prompted many to reconsider consuming beef products. These concerns were echoed by Brussels and the government being forced to act following increasing pressure from its European allies as well as the growing domestic worries, has finally succumbed and an eradication program is to be set up. Is this too little, too late? The financial repercussions are likely to ring throughout the economy and no doubt it will only be a matter of time until we experience the seriousness of these implications in our health care system.

Closer to home the Jubilee line extension program is tunneling through on to the scheduled completion and opening two years from now. This additional transport link to London Bridge would mean even greater access to Guy's, in what ever shape or form the future holds, and is likely to improve patient compliance in follow-up attendance.

On a brighter note, as the Easter vacation approaches, the weather finally seems to have changed its bitter taste and the late start to spring seems likely to end the dull and dismal preceding months. The seasonal holiday period should provide plenty of time for our Freshers to replenish their energy stores, just in time for next semesters annual rag week

Letters

We would like to hear your views on any issues raised in any of the Gazettes, or anything to do with Guy's. You may have an opinion you would like to share with the rest of the readership. We would like to see some of your points published in future issues. If you feel you want to air your thoughts please write to the editor.

You are reminded that it is at the editor's discretion whether to publish a letter and that derogatory personal references to any individual will not be acceptable. We will however do our best to let you have a say.

A Teacher Remembered

Dear Sir

I am sure that many old Guy's men will be sad to read of the death of Dr Dudley Grasby and surprised to see that his obituary made no mention of the considerable contribution he made to the training of numerous Guy's students over many years.

Those of us who spent our obstetric teaching at Pembury were indeed very fortunate. He showed endless patience in teaching us the principles of Obstetrics and Gynaecology and set us a fine example of good clinical practice and a correct consideration for our patients.

He also ensured that while we were resident in the comfortable attic flat provided by the hospital, we had access to other departments, particularly paediatrics with Dr Jacoby and orthopaedics with Mr Mayer. The final treat was to spend a day at East Grinstead Hospital in the Plastic Surgery Unit.

I would be grateful if you could print this letter as a thank you from all of us who benefitted from his skill and knowledge and enjoyed his warm hospitality

Yours faithfully,

P J Stiles

Second rate Hospital?

Dear Sir

I was very interested to read the letter from A S Horner in the November/December 1995 issue of the Gazette. I also agree that Professor Hughes has presented the situation as it really is and he and those associated with him should be thanked for their great effort in trying to save Guy's.

I have recently received a publication of UMDS called the 'Check-up' from St Thomas' Hospital' which states that it is intended for both St Thomas' and Guy's alumni. In it, Professor Chantler advises that Guy's will now become what is interpreted as a glorified Dental Hospital and a large out-patient clinic.

Unfortunately, no matter how one tries to soften the blow, Guy's has become a secondary institution to St Thomas' Hospital.

Yours faithfully,

Robert Walton

Guy's safe with Labour?

Following a quote by Harriet Harman, Shadow Health Secretary, in the South London Press titled 'Guy's may not be safe with us' and stating that 'A teaching hospital would not necessarily be safe in the hands of a Labour government', she responded to the newspaper in March complaining that she was misquoted. She then went on to promise that 'Labour would secure the future of Guy's' and that 'Guy's provides much-needed local services to my constituents , a high proportion of whom are unemployed, on low pay or live in poverty. First-class services are a way of redressing deprivation in inner city areas.'

Hallett Prize

Dr Mark Cheetham has recently been awarded the Hallett Prize in the recent Primary FRCS examinations at the Royal College. This latest accolade now brings the total of Hallett Prize winners from the demonstrator staff at UMDS to 4 in the last four years.

Nurse Remembered

Brysson White, a former RCN fellow and DNE at Guy's who died last year was remembered recently by staff and patients at the Barnes Day Hospital where she worked as a volunteer after her retirement from Guy's. In recognition of her tireless efforts, the hospital has now been renamed the Brysson White Rehabilitation Unit.

Gold Service

In a recent ceremony held by the Trust in the Robens Suite at Guy's, several members of staff were acknowledged for their continuous service at the hospital. The loyal recipients included Drs Ogg and Knight, who were awarded for 25 years service on the clinical staff at Guy's. Other people to be honoured included Ronald Harper, an engineer in the dental school, who is continuing the family association with Guy's, which now spans three generations. The recipients were greeted by Trust Chairman, Sir Kenneth Eaton, who congratulated them and praised them for their allegiance.

Evelina Appeal

Saracen of 'The Gladiators' came to Guy's on Valentine's Day to launch the Evelina Heart Appeal to raise funds for the diagnosis and treatment of congenital heart disease.

Saracen was introduced, and attention was drawn to his courage and muscles; the attention was hardly necessary, for his bulging biceps were there for all the children to see, and the parents to admire. Other visitors included members of ECHO - the parents Heart Support Group, and last but not least, nurses and doctors of the Guy's Children's Heart Department. Professor Michael Tynan paid a lightning visit to cut the birthday cake.

Also present, and a very special visitor, was an old heart patient of Guy's. At birth in 1933, Edward Mansell was a blue baby with Fallot's tetralogy. When Alfred Blalock, from the Johns Hopkins Hospital came to Guy's in 1947, to demonstrate the Blalock-Taussig shunt to Mr Brock, Edward was the second referred patient to have the operation outside of the USA. 'The result was remarkable', says Edward; I became pink, stopped squatting and was able to run about like a normal child. The shunt lasted until 1972 when the late Alan Yates carried out a total correction, and Edward has never since looked back. He continues to be a model patient, and is a frequent visitor to Guy's, confusing both under- and post-graduate students.

It may be remembered that one year after Alfred Blalock's visit, the late Lord Brock carried out his own direct operation relieving the obstruction in Fallot's by a first stage procedure - another first at Guy's. Since then, there have been many advances in heart surgery, by Donald Ross, Alan Yates, and David Anderson, and more recently in innovative techniques by the Guy's Paediatric Cardiologists, benefitting thousands of children and adults all over the world.

Michael Joseph

Guy's Hospital Gazette

English Pewter 1 pt Tankards, Engraved with the Guy's Crest, available only from the *Gazette*, individually boxed.

Price £22+£1p&p

ORDER FORM

Name .....

Address .....

.....

Please send me . . . . . Guy's Tankards at £22+£1 p&p

I enclose a remittance of £.....

To: The Manager, Guy's Gazette Office,
Guy's Hospital, London SE1 9RT
Tel: 0171 955 5000 ext 5413
Personal Callers Welcome

Office hours: Monday to Friday 1–5 p.m.

The Guy's Hospital Staff Round: Case Reports

Hypertension in Children

Systemic hypertension in children has an underlying cause in 90 percent of cases, with coarctation (in infancy), renal parenchymal disease, renovascular disease or rare endocrine causes being the most important.

Case history and clinical findings

A 10 year old boy with a 6 month history of nocturia and enuresis together with a month's history of weight loss presented with severe frontal headache, photophobia and vomiting for one week. He had been eating neat salt for one year. On admission to another hospital he had a three minute generalised convulsion. His blood pressure was 190/130 mmHg with no evidence of papilloedema, haemorrhages, exudates or focal neurology. Sublingual Nifedipine and intravenous Hydralazine did not reduce his hypertension. He became comatose. On transfer to a local Paediatric Intensive Care Unit his hypertension responded dramatically to an infusion of Labetolol, 1mg/kg/hr, such that it had to be discontinued after 4 hours when his blood pressure fell to 110/70 mmHg. Regular Atenolol and Nifedipine subsequently did not control his hypertension satisfactorily. Later the addition of Prazosin improved his blood pressure control to levels around 110/70 mmHg.

Physical examination on admission to Paediatric Intensive Care Unit revealed 5 percent dehydration, normal facies and oral mucosae, no skin lesions, equal blood pressure in all limbs and no audible abdominal bruits. The pulse rate was 120 per min, regular and blood pressure 160/110 mmHg. There was no evidence of cardiomegaly and there were only two heart sounds. Fundoscopy was normal. Electrocardiogram did not demonstrate left ventricular hypertrophy and chest radiograph showed no cardiomegaly. His plasma creatinine was 87 mmoles/L.

He underwent investigation for the underlying cause of his hypertension.

* Renal ultrasonography demonstrated the right kidney to be 8 cm and the left 8.9 cm in length (normal 10y old mean +/- SD = 9.71 +/- 0.9 cm). The left renal parenchyma appeared echogenic.
* Dimercaptosuccinic acid (DMSA) renal isotope scanning showed 21 percent differential function on the left (see enclosed report).
* Methylacetylglycine (MAG3) renal scanning did not demonstrate a delay in peak activity but confirmed reduced function of the left kidney.
* Samples for peripheral plasma renin activity and urinary catecholamines and metabolites were obtained and assayed (Table 1).

He was transferred to Guy's Hospital with a suspected diagnosis of left renal artery stenosis. Examination revealed a tense, anxious boy with very anxious parents. His blood pressure was 140/90 mmHg. Urinalysis showed a trace of haematuria and was negative for proteinuria. Urinary electrolytes were not measured. An electrocardiogram showed normal sinus rhythm with first degree AV block. ASOT was raised at 1600 Units. Supine and erect catecholamine levels were measured (Table 1), and he underwent a Doppler ultrasound. The ultrasound differed from the first examination in that the left kidney was significantly smaller (by 1cm) than the right. Doppler waveform was normal.

A percutaneous aortogram was performed. This demonstrated a single renal artery on the right and two renal arteries on the left; the lower pole artery appeared normal and supplied slightly less than half of the kidney (fig 1). The left upper pole renal artery had a long severe distal tubular stenosis with a delayed upper pole nephrogram. Selective sampling of the common iliac, left and right renal veins were carried out for active renin concentrations. The left renal vein renin activity was higher than the right (Table 1, ratio 1.41) but the right was not suppressed.

Elective percutaneous renal angioplasty was then performed. Initially a selective left upper renal arteriogram was carried out. Before the first injection of contrast into the left upper pole artery, the child's blood pressure was

controlled around 130/85 mmHg on Atenolol 100mg od, Nifedipine 20mg bd

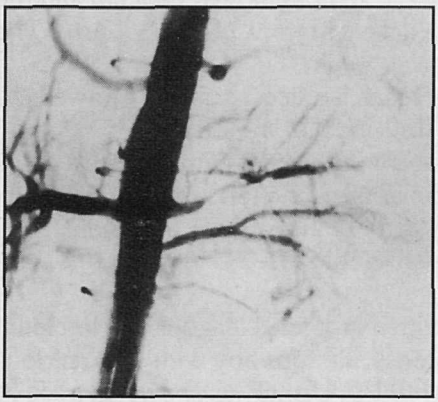


Figure 1. Percutaneous aortogram showing a long tubular stenosis of the upper pole renal artery, normal lower left renal artery and its branches and a normal single right renal artery. A delayed nephrogram affecting the left upper pole was noted.

and Frusemide 40mg od. The arteriogram demonstrated the long severe tubular stenosis extending up to the first major branch together with a round hypervascular mass just medial to the hilum of the left kidney (fig.2). This mass obtained its blood supply from the upper pole renal artery via an adrenal branch. The radiographic appearances were consistent with phaeochromocytoma. Immediately following the first radiocontrast injection, his blood pressure rose from 100/70 to 160/100 mmHg. No increase in urinary catecholamine excretion was demonstrated after this hypertensive crisis which had occurred during the procedure. Subsequent injections into the single right renal artery and the left lower renal artery showed no renovascular abnormality and were not associated with labile hypertension. Computerised tomography and radioisotope metaiodobenzyl guanidine (MIBG) scans subsequently confirmed a single peri-adrenal mass adjacent to the left kidney.

A left total nephroadrenalectomy was subsequently performed; histochemical examination confirmed a benign phaeochromocytoma. Our surgeon elected to combine complete excision of the tumour with left nephroadrenalectomy because of the position of the phaeochromocytoma adjacent to the hilar renal vessels - the extensive dissection required may have put the patient at

risk of further hypertensive crises. Selective excision of phaeochromocytoma followed by spontaneous resolution of the associated renal artery stenosis has been described [2]. Postoperatively he was weaned off all antihypertensive treatment within three days and has remained normotensive since. He remains under long-term observation because extraadrenal phaeochromocytomas at this site may be both multiple and recurrent.

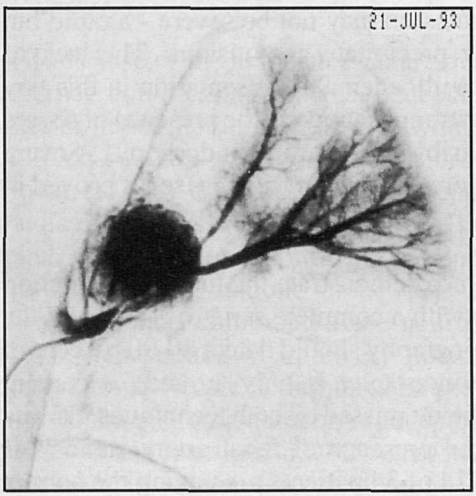


Figure 2. A later selective upper left renal arteriogram prior to elective balloon angioplasty showing a well circumscribed tumour circulation overlying the long tubular stenosis observed previously. Hypertension (160/100 mmHg) occurred imediately after injection of radiocontrast material.

Discussion

The association of renal artery stenosis and phaeochromocytoma was first reported in 1958 by Harrison, Gardner and Dammin [3]. Currently there are about 100 cases reported in the literature, 14 percent occurring in children from age 5 years onwards [4-6]. There is an equal sex prevalence; 4 percent are bilateral phaeochromocytomas and 4 percent of patients have duplex kidneys on the affected side. Mortality is around 5 percent.

There are many interesting facets to this case which are explained by the pathology. Firstly the ingestion of neat salt, with the patient taking several teaspoonfuls per day, was driven by the natriuresis and diuresis caused by the

hypertension. Hypertension commonly promotes a pressure diuresis and natriuresis by glomerular hypertension. The resulting dehydration, low normal values of the plasma sodium and potassium and raised peripheral plasma renin activity [7] produce secondary hyperaldosteronism, and are easily differentiated from primary hyperaldosteronism due to an adrenal tumour (Conn's syndrome) where fluid retention, normo- or hypernatraemia and hyporeninaemia are usually found. The lack of clinical evidence of end organ damage is consistent with a relatively short clinical history of very severe hypertension. Children with raised blood pressure often develop seizures as the first sign of hypertension and the degree of hypertension may not be severe - a rapid but moderate rise in blood pressure may precipitate convulsions. The lack of retinal haemorrhages, exudates and papilloedema at presentation in this boy with severe hypertension and seizures strongly supports the presence of severe arteriospasm, which was probably visible on careful fundoscopy. Severe hypertension commonly means that there is an underlying cause, as proved in this case.

Secondly, the initial aortogram did not demonstrate the tumour circulation despite an adequate first examination with a complete series of films and the tumour being well vascularised. Arteriography should detect 80-90 percent of phaeochromocytomas whereas ultrasonography is only around 70 percent sensitive; small extraadrenal tumours being missed by both techniques. Failure to identify phaeochromocytoma in the presence of renal artery stenosis is commonplace. Hill et al [4] reported 14 of 34 patients not having the correct diagnosis made prior to surgery, with one patient dying soon after arteriography. The other patients experienced no apparent harmful long-term sequelae. Magnetic resonance imaging has a high diagnostic sensitivity for phaeochromocytomas (approximately 90%) but may miss associated renal artery stenosis [8]. In general, if phaeochromocytoma is suspected, priority should be given to confirming its presence before renovascular causes are investigated.

Thirdly, our biochemical screening showed mild elevation of noradrenaline without raised plasma adrenaline and the catecholamine response on coming upright was intact. Extramedullary phaeochromocytomas lack glucocorticosteroid induction of phenylethanolamine-N-methyl transferase (PNMT) so are not associated with raised plasma adrenaline concentrations, which increases

the diagnostic sensitivity of catecholamine overproduction [9]. We interpreted these mild elevations in noradrenaline as being due to an anxious ill child undergoing venepuncture and hypotensive therapy (particularly Labetalol and calcium channel blocking agents. The level of noradrenaline and the preserved changes in concentrations with posture, in relation to the values reported by Brown et al [9], was thought as being inconsistent with phaeochromocytoma. A clonidine or pentolinium suppression test was not performed. Small phaeochromocytomas required the use of these sensitive tests to exclude their presence.

The cause of the associated renal artery stenosis is not known. Obviously, external compression by the phaeochromocytoma may compromise the arterial lumen. Other pathologies which may cause renal artery stenosis in children by these means include neurofibromatosis and tuberose sclerosis. However, high concentrations of locally-released catecholamines or other mediators have also been proposed. Brewster et al described resolution of renal artery stenosis following adrenergic blocking agents and surgical removal of the tumour alone [2]. As in this boy's tumour, phaeochromocytomas commonly have neuropeptide Y on histochemical staining [10]. Neuropeptide Y is a very potent renal and splanchnic vessel vaso constrictor molecule acting through pre and post-synaptic receptors distinct from alpha and beta-adrenergic receptors. This may explain the near absent perfusion and function on DMSA and MAG_3 isotope scanning. Hence several reasons exist why renal artery stenosis may develop in association with phaeochromocytoma.

Table 1. Biochemical Investigations

Local PICU

Peripheral blood:
Na 136 mmol/L
K 3.1 mmol/L
Urea 3.5 mmol/L
Liver function tests normal
Renin Activity 8.9 pmoles/L/hr
Aldosterone 2488 pmoles/L

Urine:

24 h Vanilylmandelic acid 25 umole
24 h Homovanilylic acid 22 umeol
24 h 5-OH-indole acetic acid 12 umoles
24 h Adrenaline 0.06 lumol)
24 h Noradrenaline 1.23 umol)
24 h Dopamine 0.79 umol)

Guy's Hospital

Peripheral blood:

Na 133 mmol/L
K 2.8 mmol/L
Urea 3.0 mmol/L
Creatinine 59 umol/L

Venous Blood Gas
pH 7.41, PCO_2 6.24 kPa, PO_2 6.0, Std HCO_3 30.2 mmol/L, base excess 5.3 mmol/L

	Adrenaline nmoles/L	Noradrenaline nmoles/L
supine	0.10 (NR 0.01-0.55)	4.72 (NR 0.60-3.55)
erect	0.19	6.00

NR = normal range

Acknowledgements
I wish to thank Professor John Swales for his helpful comments when the case report was presented to him as a clinico-pathological case conference.

References

1. Causon RC, Brown MJ (1982) Catecholamine measurements in pheochromocytoma: a review. Ann Clin Biochem 19: 396-404

2. Brewster DC, Jensen SR, Novelline RA (1982) Reversible Renal Artery Stenosis associated with Pheochromocytoma. JAMA 248: 1094-1096

3. Harrison JH, Gardner FH, Dammin GJ (1958) A note on pheochromocytoma and renal hypertension. J Urol 79: 173-78

4. Hill FS, Jander HP, Murad T, Diethelm AG (1983) The coexistence of renal artery stenosis and pheochromocytoma. Ann Surg 197: 484-490

5. Raghavaiah NV, Singh SM (1976) Extra-adrenal pheochromocytoma producing renal artery stenosis. J Urol 116: 243-245

6. Burns AP, O'Connell PR, Murnaghan DJ, Brady MP (1989) Bilateral adrenal pheochromocytomas associated with unilateral renal artery stenosis. Postgrad Med J 65: 943-947

7. Hiner LB, Gruskin AB, Baluarte HJ, Cote ML, Sapire DW, Levitsky D (1976) Plasma renin activity and intra renal blood flow distribution in a child with pheochromocytoma. J Pediatr 89: 950-952

8. Slavis SA, Geil GE, Martin DC (1990) Extra-adrenal pheochromocytoma causing renal artey stenosis and implications of magnetic resonsnce imaging as diagnostic tool. Urology 35: 276-2789.

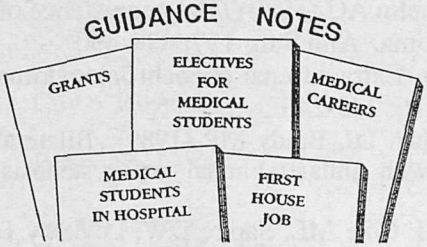
9. Brown MJ, Allison DJ, Jenner DA, Lewis PJ, Dollery CT (1981) Increased sensitivity and accuracy of pheochromocytoma diagnosis achieved by use of plasma-adrenaline estimations and a pentolinium-suppression test. Lancet 1 174-177

10. Adrian TE, Allen JM, Terenghi G, Barcarese-Hamilton AJ, Brown MJ, Polak JM, Bloom SR (1983) Neuropeptide Y in pheochromocytomas and ganglioneuroblastomas. Lancet 2 540-542

Godfrey Clark*, John Reidy, Barry Hartley
Departments of Paediatric Nephrology, Radiology and Histopathology
Senior Lecturer in Paediatric Nephrology, UMDS

ARE YOU A MEMBER?

BMA



OTHER BENEFITS FROM THE BMA:

* BMJ/Student BMJ
* BMA News Review every month
* Free Guidance Notes
* Individual Advice

OTHER BENEFITS FROM BMA SERVICES LTD:

* New Elective Travel Insurance Policy
* Advice on first Mortgages
* Car Hire Discounts
* Medical Equipment at Discounted Prices
* Student Loans

COME AND MEET US AT OUR REGULAR TALKS
HELD IN THE STUDENT BAR

BUFFET LUNCH

May 3
1 o'clock

'Contracts and Pay'

Mr. David Barr: BMA Industrial Relations Officer

Lord Brock Memorial Essay Competition

Sir William Osler, The Medical Educationalist

This month, we have included another essay which was one of the finalists from last year's competition. Entrants for this year's competition are reminded that the closing date for the essays is 31st August, 1996.

As a student representative on the medical education committee at Guy's, I have had a keen interest in the methods used to teach us the art and science of medicine. It is said that a lot is learned by studying methods of teaching undertaken in the past and it seemed fitting to illustrate how Sir William Osler's methods of teaching are very much still alive in the medical curriculum of today, more than seventy-five years after his death.

When William Osler died in 1919, he was probably the most famous and beloved physician in the English-speaking and perhaps the whole world. His renown was not due to his contributions to science, which were small, or his contributions to medicine, though they were sizeable. He adored and fascinated the young and he transformed medical education in North America and elsewhere. Before Osler, the relations between teacher and student, teacher and teacher, and teacher and patient had been cold and formal. After him, the relations were warm and friendly. He personified the learned, scholarly, skilful physician who was also a warm human being. A student of Osler's wrote, 'It is good to be so near Sir William. He does not dislike anyone. He sees good and something to admire in everyone, and I've seen his face cloud up when someone repeated a bit of scandal or criticism. He is full of vigour and energy.'

William Osler was born at Bond Head in Western Ontario on July 12th 1849. He was the youngest of the nine children of the Rev. Featherstone Osler and his wife, Ellen. They had moved from Cornwall, England to Canada, where

his father was an Anglican Missionary. William grew up to be a bright athletic boy and was a leader among his friends, especially in behaviour of a mischievous nature. In January 1866, Osler joined Trinity College School in Weston. His parents hoped he would learn music and cultural graces in preparation for becoming a clergyman. However, William was inspired by the warden, the Reverend William Johnson, to the study of nature. He enjoyed collecting on the field trips, mounting specimens and using the microscope. In the 1860's very few people in America were familiar with this instrument and it's use was not taught to medical students! This is very different to the present day when many afternoons are set aside for medical students to diligently study histopathological specimens. Around this time Osler acquired a copy of Sir Thomas Browne's 'Religio Medici' which influenced him greatly and thirty-eight years later he delivered an address on the Religio Medici at Guy's Hospital, London. He went on to graduate head of his school in June 1867.

William Osler entered Trinity College in Toronto in the autumn of 1867 with the intent of becoming a clergyman like his father. However he continued to pursue his interests in biology with Rev. Johnson and his friend Dr. James Bovell. Osler spent only one year at Trinity College in the Arts Program. Since none of his four elder brothers selected their father's profession, William Osler surely disappointed his parents by wishing to study medicine, but they understandingly accepted his decision. He entered the Toronto Medical School in October 1868 and, under the fatherly tutelage of Doctor Bovell, applied himself industriously to the preclinical subjects for two years.

Bovell's life served as a warning as well as a model. He lacked organisation and punctuality, and dissipated his energies through attempts to interpret the mysteries of life simultaneously from scientific and religious view-points. Yet, he stimulated his pupil in the available laboratory methods and, at the same time, influenced him to read widely from the great books of science and literature. Though Osler avoided his teacher's pitfalls, Bovell's influence was powerful and enduring. Indeed Osler is described by Cole, one of Osler's colleagues at John Hopkins, as 'always arriving early and always promptly at the hospital with his mind as well as his body geared to high speed.' When Bovell was planning to leave Toronto for the West Indies, he recommended that Osler transfer for the autumn term of 1870 to the older and more renowned

Mcgill Medial School, Mcgill in Montreal which was the largest Canadian city at the time and which had better clinical facilities.

At the age of twenty-one, William Osler had a fine personality and enjoyed nature studies and the company of people younger and older than himself. Although he did not always get A's in his class-work, he enjoyed reading deeply and widely. The Mcgill medical teachers provided excellent bedside instruction, and made clinical clerking a serious business. Doctor Palmer Howard was appointed Dean of Medicine at Mcgill in 1882 and was immediately attracted by the curiosity and industry of the young William Osler, whose special ability with the microscope provided information to supplement the studies of both students and professors. William Osler graduated in 1872 with a prize for his final thesis, which was illustrated by many microscopic specimens.

Osler went abroad for two years postgraduate education. He spent the first year in Britain. While working in the laboratory of Professor Bundon - Sanderson at University College, London, Osler discovered the third type of blood corpuscle, the platelet. These corpuscles had been observed before, but no one before Osler had studied them so thoroughly. Thus began what he called his periods of 'brain-dusting' - travel and studies that made him almost as much a part of Europe as of America.

Osler returned to Canada and began general practice in Dundas but was soon appointed lecturer in the institute of Medicine at Mcgill. He became professor there in 1875 at the ripe old age of twenty-six! At Mcgill he taught physiology, pathology and Medicine and he continued his research, which was largely conducted in the post-mortem room. In 1884, whilst in Leipzig, he was invited to occupy the chair of clinical medicine in Philadelphia. He decided to do so on the toss of the coin. While in Philadelphia, he became a founder member of the Association of American Physicians.

In 1888 Osler accepted on invitation to be the first Professor of Medicine at the Johns Hopkins University Medical School in Baltimore. There he joined William. H. Welch, Chief of Pathology, Howard. A Kelley, Chief of Obstetrics and gynaecology and William. S Halsted, Chief of Surgery. Together, the four

transformed the organisation and curriculum of clinical teaching and made Johns Hopkins a famous medical school throughout the world. Students studied their patients on the wards and presented the results to the 'chief' (as Osler was nicknamed). This is not too dissimilar to the way we learn medicine at Guy's today. However, the students were also encouraged to take their problems to the laboratory and therefore develop research skills which nowadays are only possible if one undertakes a BSc Finally, the experts pooled their knowledge for the benefit of the patient and student in public teaching sessions. This may be paralleled to the traditional Wednesday lunchtime Grand Ward Rounds held at Guy's.

For the first four years there were no students at Hopkins, and Osler used the time to write 'The Principles and Practice of Medicine', first published in 1892. In the same year he married Mrs. Grace Cross, widow of a surgical colleague at Philadelphia. Osler's textbook was lucid, comprehensive, interesting and scholarly and quickly became the most popular textbook of its day. However, Osler believed that Medicine could not be learned from books alone and bedside teaching was of the utmost importance. 'In what may be called the natural method of teaching, the student begins with the patient, continues with the patient, and ends his studies with the patient, using books and lectures as tools, as means to an end.'

The great talents of Osler were well exhibited in his work as teacher. He extended his influence and made the employment of his methods more widespread by developing and training members of his staff. The value of the intern systems had been well demonstrated elsewhere, but Osler saw that the short period of one or, at the most, two years of service in vogue elsewhere, was not sufficiently long in which to train scholarly and scientific habits. By retaining the most capable men under his tutelage for longer periods, the best of them for five or six years, or even longer, it was possible to develop a group of men thoroughly trained in the methods of exact observation, who themselves extend the boundaries of knowledge.

His greatest originality as a teacher was shown in his work with students who for first time were coming into contact with their patients. He taught them by joining in the examination of patients chosen at random, whom neither he

nor the students had ever seen before. With no other aids, teacher and students attempted to learn all they could by observation alone. They employed the method of Zadig, that of making deductions or inferences from inconspicuous features. The sessions, as exciting as following the trail of a murderer, were thrilling experiences for the students. Having arrived at a diagnosis, the students were told how to look up the literature dealing with the condition, and subsequently brought the material - often the original description - to class. The students were thus introduced to the best in medical literature. Careful records were kept by the students, and after a number of patients with the same condition had been examined, a tabulation of the results by the students gave a composite picture, which served as an introduction to the statistical method. The student thus received more than a preliminary training in diagnosis. Osler's ready wit helped to make the sessions most interesting and amusing, as well as instructive. J.B. MacCallum, a student at the John Hopkins (1896-1899) writes:

'I was called up in Osler's clinic... They are the nicest things we go to, for Dr. Osler sits on the table and swings his feet and asks you all sorts of questions you have never heard before.... Dr. Osler's clinics are splendid. It was so nice to hear him talk to patients. He has a joke for everyone.'

Of course, Osler demonstrated a kind of showmanship when he taught, but it was a very different kind of showmanship from that which was traditional among professors of Medicine who assumed attitudes of profound gravity and unlimited learning and, pompousity and with oratoric embellishments, gave lectures consisting mainly of medical aphorisms based on opinion and authority. Osler employed none of these tricks and remained an unpretentious, modest man. He was able to walk with nobility and still keep that common touch.

'The successful teacher is no longer on a height, pumping knowledge at high pressure into passive receptacles...he is a senior student anxious to help his juniors.'

The more advanced students spent their time in the wards, and Osler's teaching there was always of the same informal character, with the patient before him. Osler did not, however, introduce bedside teaching. Over two hundred years before, Franciscus Sylvius had taught students beside his twelve

beds in the hospital at Leyden, and he and his successors made that university a mecca for medical students from all over Europe. But never before the time of Osler had the students become a part of the ward organisation or taken so active a share in the study of the disease.

In 1904, whilst visiting in England, Osler was invited to succeed Sir John Burdon-Sanderson in the Regius Chair of Medicine in Oxford. Osler's practice and teaching had for many years imposed enormous demands on his time and energy. His forceful wife telegraphed him from America 'do not procrastinate. Accept at once.' Osler did. The Regius chair at Oxford is a Crown appointment for which only the citizens of the crown were eligible, but Osler had kept his Canadian nationality. He took up his chair in the autumn of 1905. In Oxford he had taught only once a week, did a small amount of practice, and spent most of his time on books. His library became one of the best of its kind, and after his death it passed intact on to Mcgill, where it is specially housed. He was elected a fellow of the royal college of Physicians of London in 1884 and Fellow of the Royal Society, of London in 1898; he became a baronet in 1911.

Osler gave many lectures, mostly on the subject of medical history and literature, some of which were collected and published. Aequanimitas, which he regarded as the most desirable quality for doctors, was the title of the most famous of these. Osler had a puckish wit and wrote some admirable medical nonsense under the pseudonym of Egerton Yorrick Davis, a retired surgeon captain of the U.S. army.

In medical terminology, Osler is immortalised in Osler's nodes (red, tender swellings in the palm or palmer surface of the fingers and hands in subacute bacterial endocarditis), Osler - Vaquez disease (polycythaemia rubra vera), and Rendu - Osler - Weber disease (a familial form of recurring nose bleeds with multiple teliangectases of the skin and mucous membranes).

The Oslers had one son, Revere, named after his great-great-grandfather, Paul Revere. His death in action during World War One took the spirit of his father, who died of pneumonia on December 29th 1919. His funeral was in the cathedral and chapel of Christ Church at Oxford on January 1st 1920. Lady Osler died in 1928. Her ashes, and those of Sir William, are now in the Bibliotheca Osleriana at McGill.

It is perhaps fitting to conclude this essay of such a famous physician with an epitaph. What could be more fitting than quoting Sir William Osler himself:

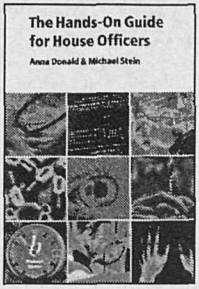
'I desire no other epitaph...than the statement that I taught medical students in the wards, as I regard this by far the most useful and important work I have been called upon to do.'

Biography

Bean *Sir William Osler Aphorisms*
Bett W.R. *Osler The Man and the Legend*
Cole *Osler Scientist and Teacher*
Cushing H. *Life of Sir William Osler*
Fulton J.F. Osler the Humanist
Palmer Howard R. *The Chief: Doctor William Osler*
Penfield *Osler, Hero Worship*
Religio Medici *An address delivered at Guy's Hospital, Octoebr 1905*
Rosencratz Postumous Tributes to Osler

Sonya Marie Abraham

The Hands-On Guide for House Officers



Anna Donald & Michael Stein

256 pgs, 25 illus, paperback, 0865429219, £12.95, May 1996

The Hands-On Guide for House Officers is a practical book written by junior doctors for house officers and medical students making the transition from Medical School to life on the Wards.

How do you prepare for the physical and emotional rigours of your first year as a doctor?

First, don't panic. Second, read this book.

It tells you:

- **what to expect in the first week**
- **how to discharge patients, run your own night rounds and tone down your bleep**
- **how to prescribe and give drugs**
- **how to sign cremation forms, insert central lines and read ECGs**
- **how to be proficient in Accident and Emergency**
- **how to organize paperwork, maximize your pension and get more sleep**
- **how to practise evidence-based medicine**
- **how to manage GI bleeds, overdoses and oliguria**
- **how to talk to fraught relatives and organize your next job**
- **how to select a computer and start your own medical database**
- **how to perform chest drains**
- **how to prepare diabetic patients for surgery**

...and everything else you need to know to pass with flying colours!

b Blackwell Science

For further information and ordering details please contact Lucy Brodie, Blackwell Science, Osney Mead, Oxford, OX2 0EL
Telephone (01865) 206076; Fax (01865) 206096

b Blackwell Science

An Interview with Dr William Gransden

Pus changed my life

Dr Gransden is a consultant microbiologist at Guy's hospital. He qualified in 1978 after doing three years pre-clinical at Cambridge and his clinical period at St Thomas'. He lectures both students in the pre-clinical and clinical pathology courses and was last year given the SMEC award for 'Best Clinical Teacher'.

Why did you choose to study medicine and what were your medical school days like?

I don't really know why I chose medicine. It seemed like a good idea, a good career and a lot of respect from the general public although I think that is declining greatly these days. My medical school days were wonderful, I had such a good time. I think this ties up with why I teach because I can remember exactly what it is like to be a student. I did my pre-clinical in Cambridge which was marvellous because you were mixed in with all sorts of people doing other courses, not just medical students. Then I came down to Thomas' which was like starting all over again. We met people from 'The London' and there was also an intake from Oxford so there was a great mixture of people. Three years in Cambridge was idyllic and three years in London was so much fun, so I enjoyed every day as a medical student.

Did you do anything outrageous when you were at medical school?

Well I did the typical student things, getting drunk and misbehaving at parties. I do remember that in between my pre-clinical and clinical period in 1975 I did the hippie trip around India with a young lady who is now a consultant at Great Ormond Street Hospital. An interesting thing happened to us when we were in Leh. A Himalayan Chief of Police took a fancy to her and I was offered any women in the village in return for her.

When and why did you decide to choose microbiology?

I really don't think students know what a microbiologist does. Many physicians and surgeons don't know what we do either. I started off doing surgery, training as a surgeon and did primary fellowship, FRCS which again meant going back to being a student. So undergraduate exams aren't the end of it - they go on and on. When I was doing the fellowship course I did a full time job in microbiology and found it very interesting because it is very clinical and you are involved in the management of patients with severe infections. I then went back and continued to do my surgery and it just seemed that microbiology was more interesting, more fun and less stressful. There is no doubt that doing surgery is extremely stressful and I wanted to have a life outside medicine. I think that surgeons who want to get on have got to be 120% committed to it. The link I think is pus because in surgery in many of my jobs all I did was drain abscesses. I remember that one whole list that I did was just draining ischiorectal abscesses which is great fun as the patient gets better straight away and then I moved into microbiology which was finding out what was in the pus. Pus seems to be the secret of my life. I was doing a casualty job in St Thomas' when one day I happened to drain a scrotal abscess and this went up to the microbiology lab and the microbiologist there, Susie Eykyn, was so intrigued by the bugs she came running down a couple of days later to find out some more details about the patient. She got talking to me and I asked whether I could get a job in microbiology while I was doing my fellowship exams and that's how I got started. I like immediacy. In surgery you make the patient better almost straight away; You go through the diagnostic process, decide what you think it is, open them up and find out then and there if you

were right or wrong. I'm very impatient and I like to know straight away what is wrong and do something about it, so surgery was very rewarding and I enjoyed it immensely. As a physician you find yourself waiting around for tests and pondering about things, putting patients on different medications. It's all to slow for me, I like hands on.

Was there a specific event that made you change to microbiology?

The specific event that I can remember is when I was an SHO in Derby in the middle of the most bleak and awful winter. It was a night when our team wasn't on call and we operated from 1 O'clock lunch time all the way through the afternoon into the night having done our actual list and extra emergency stuff. At 3 O'clock in the morning I was left on my own to finish off three appendectomies that had lined up. That was a night when I wasn't on call and I shouldn't have been up there doing any of that. I think this was actually the turning point although I had been thinking about it before as to whether I was committed enough to be a surgeon. I saw registrars ahead of me who would have jumped at the opportunity to do these operations even if they had other plans such as the theatre or dinner booked. It seemed that surgery was more important to them than their family or social life. The rewards were there for them, they were very good at their jobs but that wasn't for me. I was happy to work hard when I was at work but I wanted another life outside, although I still find that I don't forget about the patients entirely when outside. So, that's what moved me into microbiology.

What does your present job as a consultant microbiologist at Guy's involve?

It's wonderful, I'm so lucky. There are three bits to it; teaching the medical students which I get a great kick out of - I don't think we do enough of that. I do some research and I'm the clinical microbiologist giving advice on the diagnosis of infection. Most of my time is taken up by the clinical work and I don't have that much time for research. Teaching tends to come in big blocks - all of a sudden lots and lots of it. With regard to clinical work, I have ward

rounds on the paediatric and adult intensive care unit and renal unit. I also see haematology, oncology and bone marrow transplant patients, so there is a lot of contact with patients. I have a senior registrar who at the moment does the day to day liaison. If the lab rings up with a positive blood culture he goes out sees them and then comes back and we discuss it and give advice to the doctors about what needs to be done.

So are you the only consultant microbiologist at Guy's?

Well, we have recently appointed a 'control of infection doctor' who is part time whereas at St Thomas' they have five versus one and a half here.

How did you get involved in teaching?

I first started teaching around 1980 when I was suddenly told to give a microbiology lecture. I probably gave the worst lecture of my life because I tried to cram everything into it. That's the mistake that everyone continues to make again and again. I'm now employed by UMDS as a senior lecturer. We have this term 6 in the pre-clinical course and the clinical pathology course occurring simultaneously in the summer and so there is a lot of work in teaching and organising practicals and setting the exams and marking them. I also teach on the HDE (Health, Disease and the Environment) course and I give a few postgraduate lectures here and there. I prefer teaching undergraduates because I can really remember what it is like to be a medical student at your stage, I really can relate and I try to keep a rapport going.

Do agree with the present design of the final MB pathology course?

Ever since I've been teaching microbiology we have been messed around by the medical school and certain clinicians who think that they know where pathology should be taught. They say to us that the students should known everything about pathology before they come up to the wards and see patients. We say we can't teach pathology until the students know something about

patients and disease and things that happen to them. So it is a chicken and egg syndrome, which one comes first? Now the examiners are complaining that the standard of pathology knowledge in students appears to be bad because it is taught so early. Other schools who have done this tried to teach it earlier and students then can't relate to what goes on. I regard pathology as a basic science and feel that you should get some of it at the beginning and continue to get taught it further on but there is no point offering pathology in subsequent years as if you are not going to get examined on it, no student will turn up. So now the deal is that I will be one of the examiners in the final MB, the pathology will be largely clinical, so you could get myself and a surgeon or myself and a physician on a short case or an OSCE, we could bring an infection into it or pathology somewhere along the lines. So it still is there you still have to be aware of it. I would like to continue teaching students throughout the later parts of the clinical course and even beyond that. I also remember what it is like to be a houseman as that is when you start to say 'so this what the lab is for'. This is the great thing about teaching students as I get to see them again when they are housemen and registrars and higher up. Then when I'm dealing with them professionally on the phone and they ask me about a particular infection, I can remind them about how we covered it in a practical and if they still can't remember what it is all about I then ask 'who taught you microbiology?'.

So if you could change the whole pathology course to make it better what would you do?

I would make it less intense, I'd split it up into blocks. You have got to have more time to absorb all this information and I think that the students find it fascinating and realise that it is the basis of all disease. So I would like to have it extended slightly and I would like there to be a greater opportunity for smaller group teaching. If I stand up and give a lecture to 200 students in an hour that is very efficient as far as the school is concerned as I have done 200 teaching sessions in only one hour. Now, if I were to do that in smaller groups of only 20 students that would take me 10 hours of teaching and that would cost the school a lot of money as it is 10 of my hours. I would rather be doing that as I think the quality of the teaching goes way up and it more rewarding for both me and the students but there are not enough hours in the day

unfortunately and there are not enough members of staff as we are being squeezed all the time. These limitations on smaller group teaching can possibly be overcome with the use of computers. I am trying to design a system at the moment on which I want to put the whole of my microbiology course. I will be quite happy for students not to come to my lectures and use this in the library instead. Hopefully the computer system will allow students to cross-link and integrate all the information they learn during the pathology course. Also the teaching should be extended throughout the clinical course with formal teaching later on and also to offer it as a postgraduate subject. I also think the exam should be taken later. Students tend to split up pathology because it is taught that way and so they think that way but they must remember that when a patient presents they will have to bring all there knowledge together. One can see this in the essays students answer: If we ask a question on food borne disease you go straight to that lecture and churn it out. It's very sad, flattering if you have given the lecture, but it shows that the students haven't really understood what is going on only memorising it which is exactly what happens in this panicky short course. I think the lectures should relate more to patients' diseases. There should be a session on diarrhoea in which one should learn the infectious causes, the metabolic causes, the metabolic changes and so on.

Have any strange events ever occurred in your lectures?

I seem to be prone to strange events in my lectures. Last year I was completely taken aback when in mid flight about something or other a person appeared from the back of the lecture theatre with his boxer shorts swayed around his head, streaked down through the Harris and out the other side. This might have perturbed several lecturers but it didn't bother me much because the year before we had the hit squad in who 'custard-pied' somebody. The year before that we had a flasher who came in so I'm quite used to it. Last year's streaker came up to me at the post-pathology party but I didn't recognise him because he had his clothes on.

Could you tell us about your new role as co-ordinator of the pre-clinical pathology course?

Well the courses had to be reorganised in light of what the General Medical Council are saying. We have tried to reform at the pre-clinical pathology course so that it just contains the basics of pathology, so then we can make the subsequent clinical course much more clinical. In other words it contains the core pathology such as the structure of bacteria, what inflammation is etc, which can then be applied later on. We are also trying to link it with the other courses which are going on at the same time and we are bringing it back a little bit in that students will be formally examined in it as part your second MB exams. Previously you took your second year exams and then had this pathology course and exam lumped on at the end of it which few people took seriously hence we had to reintroduce the basic concepts again in the beginning of the clinical course which was a waste of time. The term 6 course was very unsatisfactory and we have rethought our lectures very carefully and have also looked at where the duplications occur. We were horrified to see how many duplications there actually are - some lectures were repeated three times over, which obviously the students spotted but we didn't because we didn't see what everyone else was doing. Now we have become much more aware of what others are doing.

Your pathology lectures are renowned for their unorthodox nature. Do you think that this is why you were awarded 'Best Clinical Teacher' at the SMEC Awards in 1995?

I thought my lectures were absolutely straight forward, straight down the line and classical. So I would do any trick in the book to get away from the lecture concept. I went on a lecture course where we were studying the ways that you learn and I remember someone saying that students read faster than you can talk, so in fact me standing there talking is not very effective. I don't regard myself as a teacher telling you what to do. I regard myself as helping students to learn. I'm on their side helping them to get through and if they don't get through, I'm the one who has failed. A lot of teachers are there trying to catch you out with trick questions but I don't believe in that. I think things

that we ask in the exam should be things that we have definitely covered. I'm quite prepared to show a picture in the exam that we have gone over in the practical class. Just listening to a lecture and reading the handout is not enough. One must do something else to use the information such as doing a crosswords. I saw some really terrible ones for the pre-clinical course and I thought I could do a bit better than that so in order to get the students to write down the words I devised some crosswords hoping the information would sink in as they were using the words is a different way. I also give problems to solve and I would love to be able to introduce case studies where you would have to go away and look things up and think about how and why certain investigations were performed and why the management was carried in a certain kind of way. It's using the information that makes the difference - simply listening and memorising is very superficial learning. If students can get this by other means then they should go and do it because I think that some people do work better on their own and are happy to read through a book.

I was really thrilled to receive the SMEC award. I've spent years teaching abroad. When I taught in Canada they had a similar award which students gave their teachers. I always thought that this was a good idea because many teachers especially in UMDS find teaching a chore. They are here to do research and they are wonderful researchers but they don't necessarily make good teachers. They come down and give their one lecture a year and go away again so there is no real reward in teaching for them. This award was a real bonus to me and I was very proud of it. I recently had to give it back for this year's award which was very sad. If you give a lecture and the students just walk out then you think 'why did I bother doing that?' I do get other rewards because I examine the students, I see them in the vivas, I see all their essays and if then they manage to treat infections reasonably as doctors that is the real reward. I wish the school would encourage those who are good at teaching to teach and give them credit for it and those who are not good at teaching can be left purely to do research.

Do you think you are a tough examiner in the pathology vivas?

No, in the pathology vivas most of the decisions have already been made because most people pass and are average and it is quite tedious to examine them all day long. There are a few people who get really tough vivas if they

are up for honours and they are an absolute delight. They usually stand out very early in the viva and when you see their written marks you often see how well they have done already. They are the ones who have normally done a lot of background reading. The bad ones may also get a tough viva but just to see if they know enough to pass. You usually can't fail on the viva alone. In order for that to happen, you have probably mucked up in the exams before. In fact, there is probably going to be a move to get rid of them and only give them to the people who are borderline or honours.

I think I give people reasonably easy vivas. When I am examining, I never mean to be malicious. I try not to tease but I may roll my eyes to heaven as if to say 'why are you saying that!' We don't 'toy' with the candidates but try to ask them straightforward questions. Everyone seems to get very worked up though, and you can see these ashen-faced students, sweating in front of you and you feel like saying 'calm down and relax, I'm not the enemy'.

How was your fifteen seconds of TV stardom, talking about MRSA?

It was extremely brief and it is very difficult to get important concepts across. Following the 'Panorama' programme, many of the public were very upset about MRSA and the BBC phoned us for an interview following the closure of Harlow hospital due to the MRSA outbreak. I initially refused but then thought that I might be able to do some good so I changed my mind. It was a very stressful situation as I was interviewed remotely with everyone else back in the studio. I had previously been on satellite and cable TV which I thoroughly enjoyed but 'live' TV is very different.

One burning question that all the students want to ask; Is your perpetual suntan real?

As I have grown older, I've found that I can't abide by the English weather. I suppose I have seasonal affective disorder in a big way! So I spend the summer here and whenever I have time, I shoot off to the Caribbean in the winter for a tan, not forgetting to pack my factor 30 sunblock. I have strong links with the Caribbean as I lived and worked there for some time and so returning there is always enjoyable.

Kate Mundray

UNITED CLUBS UNION SHOP

Boland House
Guys Hospital
London SE1 9RT
Tel: 0171 955 5000 Ext. 5947

Opening Times: Mon, Tue, Thur 12:00 - 2:00pm

TIES	
Guys Crested - polyester	£ 6.00
Guys Crested - silk	£14.50
Guys Striped - polyester	£ 6.00
Guys Striped - silk	£11.75
UMDS - polyester	£ 6.00
UMDS - silk	£14.50
GUYS TIE SLIDE	£ 7.25
GUYS TIE PIN	£ 4.00
GUYS CUFF LINKS	£ 8.50
GUYS SCARF	£11.50
GUYS / UNIVERSITY OF LONDON SCARF	£11.50
GUYS ENAMEL BLAZER BUTTONS - 2CM	£ 3.40
- 1.5CM	£ 3.25
GUYS LAPEL BADGES	£ 3.00
GUYS SWEATERS (Several colours)	£23.00
GUYS SWEATSHIRTS (All colours)	FROM £15.00
HOODED SWEATSHIRTS (Large or small crests, assorted colours)	£16.00
GUYS T-SHIRTS (All colours)	FROM £ 5.00
HONEYCOMBE T-SHIRT	£12.25
HONEYCOMBE COLLARED T-SHIRT	£14.75
POLO SHIRTS	£11.25
1/4 RUGBY SHIRTS (Navy/Bottle Green or Navy/Maroon with white collar. With Guys crest)	£15.25

POSTAGE & PACKAGING:
£1 For large items, 50p For small items.

Margaret Fendick
Shop Supervisor
February 1996

MCQs in Anatomy

This book can now boast a 3rd edition with very subtle but important changes. For instance, each question now has 5 instead of 4 options which is more appropriate to most MCQ exams.

The removal of the embryology chapter is no great loss (but relief to those of us hate ploughing through embryology!) since necessary material is included within each chapter to ensure the student doesn't miss out completely.There have also been clinically relevant questions slotted in just to balance the content of the book and to break the monotony of endless anatomical facts.Good anatomy MCQ books are hard to come by and this is certainly one of them. Although it recommends the student to combine its usage with Essential Anatomy textbook (by Lumley, Craven &Aitken), in practice I think it can be used with the students' choice of favourite anatomy textbook. (**MCQs in Anatomy**, Lumley & Craven, Churchill Livingstone, £12.50, ISBN 0443049777)

Susan Jain

MCQs in Anaesthesia

This book is designed for those taking the new two-part structured final FRCA Examination.

The breadth of clinical topics has been expanded to include medicine, surgery, applied pharmacology and anatomy. The preface is helpful at giving strategies on using the book and MCQ technique in general. It is set out in 20 papers which are of suitable length to practice under examination conditions and there are brief and to the point explanations for the answers. This seems an excellent way to help prepare for the examination especially at the bargain price of £12.50. (**600 MCQs in Anaesthesia: Clinical Practice**, Goodman & Johnson, Churchill-Livingstone, £12.50, ISBN 0443048355)

May-ai Seah

Communication Skills for Medicine

This new textbook is designed to help students learn the difficult art of effective and sensitive communication. Since many medical schools are increasingly incorporating communication skills into their curriculums, it was only a matter of time before a book was written on the subject.

This book is set out in a clear and readable style with helpful diagrams and 'Stop and Think' boxes. It tackles basic communication skills as well as breaking bad news, taking a sexual history, communicating with young children, people from different cultural backgrounds, families of patients and with other colleagues.I think that it is quite distressing that people should need to learn communication skills from a written text. I feel the best way is by role-play or actually interviewing patients. If people are afraid of talking about sex, reading about it will not overcome their embarrassment, it will just delay the task.(**Communication Skills for Medicine**, Lloyd & Bor, Churchill Livingstone £15.00, ISBN 04433051682)

MS

Pocket Examiner in Pathology

This revised second edition of Pocket Examiner in Pathology sports a new pale pink cover.

It is a very user friendly book with a clearly set out question and answer section. These are well chosen for each section and although they do not cover all the facts needed for the pathology course, they do allow you to revise or check your existing knowledge. This book is of discrete size and ideal to carry around with you,on long train journeys for instance. At the retail price of £12.00, it is however an expensive supplement to standard texts. There is so much to plough through during the pathology block as it is taught in such a short space of time (10 weeks), that only those on top of their work should consider purchasing it. (**Pocket Examiner in Pathology**, Cowen & Smiddy, Churchill Livingstone £12.00 ISBN 0443054185)

MS

Questions and Answers in Medical Physiology

On reading the preface and note to the student, this book seems concerned with posing various styles of questions and encouraging the student to adopt different approaches to problem solving. It professes to encompass a good balance of SAQs, MCQs and case-studies, which would make it appropriate for both pre-clinical and clinical students.

Following careful examination of the book, I found it conveniently divided into sections based on systems, with each section having several chapters. Each of these chapters start with basic questions on the topic and hence, basic replies aided by occasional illustrations. Important words or sentences appear in bold type which may or may not be helpful. As the chapter progresses, the questions become slightly more intricate and might end with a case history, MCQ question, or both. Thus, SAQs dominate the chapter contrary to the claim made in the note to the student. Although the answers cannot be faulted in content, I think that they are perhaps too weighed down by fact. This leads me to believe that the author has tried to include too much in the book without sticking to the intentions of it being in a question and answer format.As far as who should use it goes, I would only recommend it to pre-clinical students, even though the style of the SAQs are not exactly appropriate to exams at UMDS. At £12.95 it won't break the bank balance, but an equally good way of revising would be to stick to past papers and a good general textbook. (**Questions and Answers in Medical Physiology**, Paulev, Saunders,£12.95, ISBN0702020435)

SSJ

Core Anatomy for Students

The introduction of 3 volumes of anatomy texts is reminiscent of the Oxford Textbooks of Anatomy although the structure and contents are slightly different.

The volumes are appropriately split into 'The Limbs and Vertebral Column', 'The Thorax, Abdomen, Pelvis and Perineum' and 'The Head and Neck'.It is clearly stated at the beginning of each text that the books are not intended to be the students' main reference books and instead are to provide revision material. However, flicking through the chapters, I found the detail surprisingly sufficient to be used in conjunction with a good anatomy atlas and anatomy MCQ book - the ideal trio for anatomy learning.The material is written in an extremely readable form and (well drawn) diagrams are on hand

to help visualise complicated parts of anatomy. Indeed, the student is even encouraged to colour in some of these diagrams to aid the learning process! As with most anatomy textbooks, there is a small part dedicated to clinically relevant information ie. injury, operations etc.Once each anatomical system has been covered, there is a chapter entitled 'Summary & Revision' which encompasses a brief summary(as the title suggests) of important aspects and a set of MCQs which are always good for consolidation.One disadvantage I did find to these books, was the distinct lack of tables summarising information about muscles ie. origin and insertion, nerve and blood supply and action. Since most of know what a chore it is to learn those things, this does not go in favour of the books.I would recommend though, having a quick look at these books - it may be the style of writing you've been looking for and if not, one of the numerous other anatomy texts is sure to fit the bill. (**Core Anatomy for Students Volumes 1,2 & 3**, Dean & Pegington, Saunders, £9.95 each, ISBN 0702020400)

SSJ

The Day I Met Yvonne Moores

Who, I hear some readers, ask, is Yvonne Moores? She is Chief Nursing Officer of England and Wales, formerly head of nursing services in Scotland, and she has held senior posts in hospitals, notably in Manchester.

The day I met her she was one of the speakers at a day's conference attempting to identify the contribution nurses in the community make to Public Health. There are two principle ways in which nurses are involved in this way. Firstly, the old-fashioned hands-on approach where they are dealing with sick people needing care. The second, where they are pro-active in promoting good health. The two are not exclusive; often the former will be the point of entry for many nurses to establish the latter. There are many other roles in which nurses are employed that enable them to become involved with other health professionals and also volunteers But, to return to Yvonne Moores: she expressed such great pleasure at being invited to a one day programme entitled 'Making it Happen', hosted by our local community services provided by the Optimum Trust, that I wondered for some moments how far we were going to get beyond her grooming performance. She did ask searching questions for nurses to examine. She asked us to consider what we contributed to needs led thinking in the new NHS, and asserted the need for evidence based practice. Her statements are all very well, but the new NHS has often led nurses away from their role into management tasks more associated with the financial demands, than with clinical and health promotion aspects. Nurses may become good managers in this context, but their primary task is more commonly connected with needs, as Ms Moores rightly suggested. But for someone who is head of nursing services in this country, one might have expected more recognition of the plight many nurses have found themselves in. I was surprised, and it was at this point I questioned Ms Moores, on her statement that nurses were underused. I realise, in the context of health promotion, this may often be true. But it is precisely as an outcome of clinical activities, that they feel 'overused', and indeed, 'run off their feet', or to coin more modern phraseology - they are 'burnt out'. Ms Moores did also point out that nurses are often unfocused and under-integrated. But many nurses are not in a good position to alter their relationship with the NHS as it stands at present. Their criticisms and contributions are frequently not only not invited, but positively opposed as if it was none of their business to intrude on management decisions. Ms Moore's role is in a unique position to question how this situation arises and operated, even if she is unable, singlehandedly,

to make changes. Nurses may well be their own worst enemies. At this one day conference, where the hope was expressed to make changes happen, Maureen Theobald, Chair of the English National Board, and formerly Director of Nurse Education at Guy's, made clear her proposals that nurses need educating in multidisciplinary teams. The transfer of Project 2000 training to a Diploma in Health may bring along a new breed of nurses who are more comfortable in questioning colleagues from medical or other health fields, and even probing superior's policies. There were few questions asked of Ms Theobald on this occasion, and to some extent I felt that she and Ms Moores got off very lightly from the nurses attending this conference. This was in contrast to the questions raised with James Parnell, Assistant Director of Lewisham's Social services. Nurses in the community were more at home here - this was where their direct care was affected. A lot of community nursing care only operates successfully if there is adequate communication and co-operation between social workers and nurses. It was clear that far from feeling underused, many nurses felt that owing to inadequacies at this level, where they were left holding the baby if help could not be given quickly, they were not underused! They were overused, and often on occasion, abused.

Denis Cobell

FINNEGAN, Terence R L, MD FRCP
Died Saturday 16th March 1996 after a long illness. Former clinical tutor at Guy's Hospital and consultant physician emeritus, Derbyshire Royal Infirmary.

MAYSON, Norman J, LDS RCS
Qualified at Guy's in 1951
Died after a long illness on January 25th, 1996. He leaves a widow, Eileen, sons Howard and Richard, and six grandchildren. Greatly missed by everyone

E Mayson

Guy's 1960's Staff Nurse Figurine

Royal Worcester Porcelain - 750 Limited Edition

To those readers of the Gazette who have, since May 1995, ordered a Royal Worcester Porcelain Guy's Staff Nurse, we are pleased to be able to tell you that the figurine is progressing well and decorating will soon commence. We are confident that we shall be sending out the first figurines in April and they will be dispatched over the summer months. By the third week in February, our orders have reached 650 so that anyone still wishing to order a figurine would be wise to do so soon. For an application form, and to confirm that there are still figurines available, please telephone:

Prue Bamlett on 01223 832143

At the Nurses' League Day on Saturday 11 May there will be an exhibition of Nursing at Guy's, 1726 - 1996, where we shall have one of the figurines on display. meanwhile you may rest assured that all is well and we are grateful for your patience.

Mrs M Lamb
President, Guy's Hospital Nurses' League

Rugby

Hospitals Cup Quarter-final
St Mary's v Guy's, Teddington
31st January 1996

The Hospitals met after a week in which no league fixtures or indeed any rugby fixtures were played in Britain. A slight thaw allowed the fiercely contested Hospital's Cup quarter final to be played. The temperature hovered a few degrees above freezing but the sun was out and a day set for a running game.

The Guy's team was very similar to that which beat the combined Bart's London side in the previous round. Shane Rosier was unfortunately not allowed to play for Guy's since he was playing for England students in two days time. The first exchanges were dominated by Mary's. In fact, for the first ten minutes Guy's hardly touched as, from the kick off, they were hounded at touch and Mary's had a series of balls from the loose, recycling into the centre and back to the forwards. However, the pressure was eventually relieved when the Mary's winger dropped the ball and Guy's won the interim scrum. However, after a short period of Guy's pressure, Mary's were back on the attack. At this time their much taller pack was noted at the mine-out ball but Guy's were again showing their all-round expertise in tackling. The pressure finally told, however, when the opposition number scored under the posts. Guy's at last led the ball out, Jones held the ball up in the centre and Ugo raced over in the corner to make it 7-5. Guy's went further behind after yet another penalty had been given for offside in the ruck. A penalty given when Mary's prevented Guy's from playing a good ball, took the score to 10-8. However, Guy's went further behind after a strange incident. Rose was pushed when touching the ball down behind his goal line and after the referee had awarded a 22 drop-out he instead awarded a penalty to Mary's when he saw Rose push his opponent in return. Although Mary's missed the resultant penalty, they gathered the ball from the 22 drop-out and scored when Guy's went for the interception rather than the man had left the way clear for the Mary's stand off. This took the half-term score to 17-8. The second half was initially much more encouraging for the Guy's supporters. The pack began to win much more ball and look more comfortable in the tight. This allowed the backs that little bit more freedom and play began to be concentrated in the Mary's half. Then, within a few minutes, we saw the best and worst of John Murphy at scrum half. Firstly, he intercepted a pass between the scrum half and fly half and the ball was whipped nicely away from Davies to Jones to put Ekeowa over in the corner. This brought the score back to 17-13 and, with Guy's pressing,

seemed odds on that they would score again and win the game. Indeed, Davies was close with another kick at goal. However, the result of the game was settled when Murphy was sent off. From a Mary's 22 drop-out the ball was caught by Challacombe who thundered into the opposition ranks as he had been doing all afternoon, and when Mary's hand came over and tried to tear the ball back, Murphy in attempting to rake the ball back appeared to stamp on the player. Mary's were able to exploit the situation and scored two quick tries to finish the game. This was a bitterly disappointing result for Guy's who had gone into the game with such high hopes, particularly after their splendid win over Bart's-London. However, on the day they did not secure sufficient possession to release their running back line and the forwards looked two yards off the pace compared with their last match. In contrast, the Mary's forwards looked extremely eager for the fray and put Guy's under relentless pressure, never allowing them to settle. The cause was not helped when Davies in the back row was injured within the first few minutes and had to be replaced. Once again, the Cup slips from our grasp. Team: Baladasoran D, Evans A, Hostert L, Challacombe B (captain), barrio E, Davis P, Ryan G, Foster, Murphy J, Davies N, Breeze R, Jenkins N, Jones A, Ekeowa U, Rose M. Scorers: Tries, Ekeowa 2, penalties Davies 1.

SJC

Hospitals Cup 'A' final
Guy's v St Mary's

Having won this competition for the last 3 years (does this mean we keep the cup?) we were determined not to let our grasp slip.

The conditions were not ideal with heavy rain beating down hours before the kick off which left the pitch slippery underfoot and the ball difficult to handle. From the kick off St. Mary's took the initiative taking advantage of the indecision of the Guy's forwards. After setting up a succession of rucks and mauls Mary's released their backs who with solid handling and quick running managed to scamper over in the corner. With the conversion added this left Guy's trailing 0-7 after just 5 minutes. This stung the Guy's side into action and from the restart the forwards, having woken up, began to dominate, winning quick ball from the breakdowns and supporting the backs both at close quarters and out wide. Just as it looked as if Guy's were going to come away with nothing, our full back Mark Lewis pounced on a loose ball and proceeded to show great pace to reach the try line just before the chasing Mary's defenders, 5-7 to Mary's. The next 20 minutes brought about a stalemate with the Guy's forwards perhaps just being on top, but cruelly and slightly against the run of play the Mary's back division sliced through the Guy's defence to score a well taken try with about 5 minutes of the first half

remaining bringing the score to 5-14. Guy's, as we do so often, started the second half poorly due to lack of concentration conceding an early penalty to stretch Mary's lead to 12 points. However, showing great spirit, the Guy's forwards upped their commitment and after forcing Mary's back over their own line, Wayne Llewellyn scored a pushover try from the No. 8 position to bring the score back to 10-17. Having brought the difference back to within one score Guy's immediately went on the offensive causing panic in the Mary's ranks. Unfortunately with Guy's seemingly on top a knock on while trying to set the ball up for the backs enabled Mary's to snap up the loose ball allowing their dangerous backs quick and unexpected possession leading to an easily taken try. To the credit of all the Guy's team we did not give up spending the next 10 minutes attacking the Mary's line. With scrum after scrum and penalty after penalty the Mary's defence had to give and it was Darren Jones, the Guy's prop who turned up on the wing to score an enthralling try, a great moment for him and no less than he deserved after giving one hundred percent for the whole season (I'm sure he will be commentating on that try for many games to come!). This left only 1 minute for Guy's to find a converted try to tie the scores but with the team trying everything the Mary's defence stood firm giving them victory in a well contested and very exciting final.

Team: Darren Jones, Al Mistlen, Rich Clinton, Barney Scolefield (Captain), Bod, Ben Wood, Wayne Llewellyn, Shitter Sharp, John Davies, Ronan Brown, Jon Costello, Andy Skyme, Matt Aristu, Pat Gush, Mark Lewis.

John Davies

Guy's RFC Supporters Club

The 24th Annual reunion will take place on 20 - 21 April 1996. Dinner will be in the Roben's Suite at 7.30 pm Saturday April. The Past v Present games will take place at 3.00 pm the next day at H.O.P. Dinner tickets priced £20 are available from Dr T Gibson and Jane Williams in Shepherds House (x 4310) or Dr Simon Russell (Bleep 1324). Attendance at one or both days' events will be welcome from any who support Guy's RFC.

Boat Club

United Hospitals Sprints: Jan 1996
RESULT: Most Successful Club - 7 *wins*

Held just after Christmas to allow us greater time to organise the event, the whole club was looking forward to rowing competitively at the UH Regatta.

Despite the low key nature of the racing, the event is vital to nurture the talents of our keen freshers, to give them a chance to win against 'equal' opposition and reinforce their desire ito row. In this respect they have succeeded admirably, and some of their opposition has felt anything but equal. The ladies freshers were involved in an exciting race early in the day - unfortunately they finished just behind the Royal Free, but showed in the process that they have much potential for the future. Channelling their frustration well, those involved in the novice four took the field apart and were rewarded with a well deserved win later in the day.

The mens fresher VIII were also successful, only having two races during the day but leaving their opposition of the Royal Free and George's well behind - a win by four lengths over SGH in the final was true reflection of their technical superiority, and how well they row together as a crew. Fresher captains Howard Wright, Heloise Baines, and Ros Jones deserve much praise for their organisation, together with everyone from the first squads who has helped to coach them.

In the senior part of the club, there were wins for the mens junior IV, mens junior VIII, mens senior IV, ladies senior IV and senior mixed VIII. The ladies first VIII were narrowly beaten by a much improved London/Barts first VIII after their amicable merger, and it was also the London/Barts first VIII who were the opposition for the mens first VIII in the final. However, the day was to end in controversy. A good start was had by both crews and we were racing level until the London cox steered into us and there was a major blade clash. Being brought to a halt, both crews were separated and London issued with a warning that another clash would bring disqualification. Our second start was not up to the usual standard, as bow pair were still straightening the boat, but we set off to make up the half length deficit, only for London to cut across our bows, making another collision a formality. This left the umpire (coach Matt Gray) with an impossible decision - to disqualify the opposition and award the race to 'his' crew, or not? It was resolved by offering the London a re-race or the chance to concede. Clearly not on for racing again, they all went up in a puff of smoke, and refused to acknowledge the situation. This unfortunately resulted in the senior VIIIs prize not being

awarded - something we are trying to rectify in the near future. Overall, though it was another satisfying performance from all members of the club, where everybody did their part to once again make us the most successful hospital club.

Steve Arnold
Vice - Captain

CRICKET FIXTURE 1996 UMDS C.C 1stXI

DATE		TIME	OPPONENTS	VENUE	COMPETITION
APRIL	**24 Wed**	**11.00**	**Charing Cross**	**Cobham/HOP**	**BUSA**
	27 Sat	14.00	J.R. Hospital, Oxford	Away	F
	28 Sun	**11.00**	**King's College**	**Cobham/HOP**	**BUSA**
MAY	**01 Wed**	**11.00**	**QMWC**	**Cobham/HOP**	**BUSA**
	04 Sat	14.00	Sidney Sussex, Cambridge	Away	F
	05 Sun	11.00	Kingston	Away	BUSA
	08 Wed	11.00	Roehampton	Away	BUSA
	11 Sat				
	12 Sun	**14.00**	**Temple Sheen**	**Cobham**	**F**
	15 Wed	14.00			UL Cup Ist Round
	18 Sat	14.00	St. George's	Away	F
	19 Sun	**14.00**	**Dulwich Wanderers**	**HOP**	**F**
	22 Wed	14.00			UL Cup Qtr. Final
	25 Sat				
	26 Sun	**11.00**	**Charing Cross**	**Cobham/HOP**	**UH Cup 1st Round**
	29 Wed	14.00			UL Semi-Final
June	01 Sat				
	02 Sun	**14.00**	**Jesters**	**Cobham**	**F**
	05 Wed	14.00			UL Final
	08 Sat	**14.00**	**Rees' XI**	**HOP**	**F**
	09 Sun				
	12 Wed	14.00	Barts & London	Away	F
	15 Sat				
	16 Sun	11.00			UH Semi-Final
	19 Wed				
	22 Sat				
	23 Sun	**14.00**	**Surrey Traders**	**Cobham**	**F**
	26 Wed				
	29 Sat				
	30 Sun	14.00	King's Hospital	Away	F
July	03 Wed				
	06 Sat	14.00	Barts & London	Away	F
	07 Sun	11.00			UH Final
	10 Wed	**14.00**	**St. George's**	**Cobham**	**TOUR**
	11 Thu	14.00	Yeovilton	Away	TOUR
	12 Fri	11.00	Old Blundelians	Away	TOUR
	13 Sat	14.00	Lynton and Lynmouth	Away	TOUR
	14 Sun				
	18 Wed				
	20 Sat	**14.00**	**Surbiton**	**Cobham**	**F**
	21 Sun	**11.30**	**Burnand's XI**	**Cobham**	**F**
	24 Wed				
	27 Sat	**14.00**	**Gray's Inn**	**Cobham**	**F**
	28 Sun				
	31 Wed				
August	03 Sat	**14.00**	**King's Hospital**	**Cobham/HOP**	**F**
	04 Sun				
	07 Wed				
	10 Sat				
	11 Sun				
	14 Wed				
	17 Sat				
	18 Sun	**14.00**	**Westbourne**	**Cobham**	**F**

To Let

South of France (Albi 11 miles, Toulouse 60 miles)

On the Southern slopes of the Massif Central, in a sleepy rural hamlet with just a church and a few houses, this cool and spacious 100-year old Gascon farmhouse, fully converted and modernised, sleeps 10 (6 bedrooms, 3 bathrooms).

Swim in secluded pool with underwater lighting, sunbathe at leisure; eat al fresco in ancient poolside barn with gas barbecue and bar area. Relax in peaceful garden or take a short walk to the forest.

Ideal for touring the delightfil ancient French towns of Cordes, Castres, Montauban, Gaillac (wine district) and the beautiful countryside along the river Tarn.

£700 per week, July/August $1,00- per week, all inclusive (except telephone). Deposit required. For information, please contact:

Professor A T Diplock
Guy's- 0171-955-4521/2
Home- 01273-834448

Gazette Contact

The Guy's Gazette has recently acquired an e-mail account and for those readers and contributers wishing to submit articles in this manner may do so by sending their material in ASCII format to the following e-mail address:

g-gazette@umds.ac.uk

Readers may also contact us by facsimile transmission on the number below, however, writers are asked to make their texts legible, in typed format if possible.

fax : 0171-955-2832

A reminder to our readers both home and abroad that the Guy's Gazette may also be accessed by the internet. Our internet address is as follows:

http://www.umds.ac.uk./guys-gazette/

Changing Your Address?

Please give us SIX WEEKS' NOTICE of your move. This will help us to make sure your *Gazettes* continue to reach you.

PRINT YOUR NAME AND **OLD** ADDRESS	NAME
	OLD ADDRESS
	POSTCODE
THEN PRINT YOUR NAME AND **NEW** ADDRESS HERE	NAME
	NEW ADDRESS
	POSTCODE

Now cut out this coupon and send to:

Guy's Hospital Gazette
Boland House
Guy's Hospital
London Bridge
London SE1 9RT

FOR ALL GUY'S MEN & WOMEN

***

TO COMPLETE THE GUY'S NURSES' LEAGUE DAY OF CELEBRATION & TO MARK THE END OF AN ERA

A GRAND GALA RECEPTION

WILL BE HELD IN THE COLONNADE

on Saturday 11th May 1996

from 7.30 pm - midnight

The Colonnade will be heated, decorated and lit with chandeliers for an evening of music and dancing, with buffet and bars. Come and meet the friends of your Guy's days for a gala evening together.

TICKETS £40 EACH

***

Applications for tickets together with s.a.e. (6"x4" min) to:-GALA Sec., Guy's Hospital Nurses' League, Henrietta Raphael Nurses' Home, Guy's Hospital, St Thomas' Street, London SE1 9RT

Cheques payable to: GUY'S GALA ACCOUNT

GUY'S

HOSPITAL GAZETTE

UMDS Guy's
17 JUN 1996
Library

May 1996

- The Hopkins Experience
- Guy's Hospital Staff Round Report
- Housemans Review 1995

How would you like to earn while at university?

If you're about to pass your second MB or equivalent and want to join the RAF, why not apply for an RAF Medical Cadetship? You'll not only be well paid but also have an opportunity to fly with a University Air Squadron and visit RAF bases and medical facilities here and abroad, as well as taking a look at the Institute of Aviation Medicine.

Once you're registered, you'll start your Short Service Commission and be promoted to flight lieutenant. Initially, you'll work as a GP. Then you can either continue GP vocational training or commence training to become a consultant. Responsibility comes early in the Royal Air Force.

There are only a limited number of Medical Cadetships. To find out more, write to: Officer Commanding Institute of Health and Medical Training, Halton, Aylesbury, Bucks HP22 5PG. Please include your date of birth and present or intended qualifications.

EQUAL OPPORTUNITIES
We are Equal Opportunities employers under the Race Relations Act and welcome enquiries and applications from all ethnic groups.

ROYAL AIR FORCE

CONTENTS

146 Passim
148 Letters—Merger, Fresher 1930
149 News—Royal Visit, Gazette Appeal
152 Feature—The Hopkins Experience
161 Feature—Guy's Hospital Staff Round
166 Feature—The Housemans Review 1995
170 Feature—407 Art Club Exhibition
174 Feature—Interview with Dr. Knight
181 Reviews—Handbook of Diagnosis, Clinical Manual
183 Nursing Notes—The Fair Sex or Fair Pay?
185 Obituaries—Ian Henderson, Elideah Kilpatrick
188 Sport—Football, Cricket
192 Classifieds & Announcements

UMDS Guy's
10 JUN 1996
Wills Library

Guy's Gazette

Editor Rikin Trivedi **Assistant Editor** Paul Hayden **Sub Editor** Sue Ferguson **Features Editor** Kate Mundray **Review Editor** Susan Jain **Sports Editor** John Davies **Nursing Notes** Denis Cobell **Office Manager** Margaret Flanders.
Acknowledgement Dean Flanders.

The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

Volume 110 Number 2456 May 1996
ISSN 0017–5870

Guy's Gazette, Boland House, Guy's Hospital, London SE1 9RT. Tel (0171) 955 5000 ext 5413.

All rights reserved.

Printed by Hobbs the Printers Ltd, Brunel Road, Totton, Hampshire SO40 3YS

PASSIM

The bitter dispute that Britain finds itself in with its economic union over the BSE issue, seems to have flared the growing concerns being aired by many regarding the question of joining Europe in total unity. The concerns seem to relate to the role of the Union; what is its role if not to support its members? Certainly, the motivations driving the current isolation of Britain, from the rest of the Union, do not seem entirely based up on the health and safety concerns being offered to us by our colleagues in Brussels. Indeed it is perhaps advisable to take a broader perspective on the entire political picture and then draw ones own conclusions. Could this be yet another example of how health matters are being used more and more as an invasive political tool?

This month we are commemorating the farewell of the last of the Guy's graduating nurses and honouring their amazing achievements and glorious past. The ceremonies which will happen during the first week in May will include amongst other things an historical display around the hospital and a gala dinner. We all appreciate the enormous efforts made by the nursing staff at Guy's and although their training is likely to be no different, the days of them being known as Guy's trained are all but numbered. It is with sadness that we say goodbye to another dying part of Guy's.

As the Summer has finally set up on us let us hope that we are more fruitful in our sporting frontiers than we were in the treacherous Winter. The boat club have done us proud with many triumphs but let us hope that are sporting talents are not solely aquatic.

Letters

We would like to hear your views on any issues raised in any of the Gazettes, or anything to do with Guy's. You may have an opinion you would like to share with the rest of the readership. We would like to see some of your points published in future issues. If you feel you want to air your thoughts please write to the editor.

You are reminded that it is at the editor's discretion whether to publish a letter and that derogatory personal references to any individual will not be acceptable. We will however do our best to let you have a say.

Merger

Dear Sir,

I read the January newsletter published jointly by UMDS and KCL with amazement and mourning anger.

There were frequent references to King's College (KCL), King' s College Hospital, St.Thomas' Hospital and to UMDS.

But Guy's quickly became 'London Bridge' or the 'London Bridge Site' and remained so throughout the piece. There must be many like me who have known and loved Guy's, who will be indignant at the blatant attempt to marginalise us in the merger.

If the merger does go ahead - and it should be if and not when-the key hospital in it cannot be sensibly be 'the London Bridge site', it is Guy's !

Yours faithfully,

J Johnston

Fresher 1930

Dear Sir,

We not only read about the disgraceful behaviour of the freshers but also the bad manners at the Dental Ball. Some of the blame must be attributed to those responsible for the choice of students. It appears today the students have too much money.

During my last three years as a medical student, my father was unable to pay my hospital fees. Thanks to Professor Johnson, the Dean, I agreed to pay after I qualified , which I did. I had an allowance of ten shillings-a-week for a midday meal, one packet of cigarettes and two half pints of beer a week.

Yours faithfully,

E L Moll

Royal Visit

Her Royal Highness The Duchess Of Kent opened the new Children's Intensive Care wing at Guy's Hospital.

Marie Claire, aged 11, an Evelina patient who suffered from nephrotic syndrome, presented a posy to welcome Her Royal Highness on arrival to open the new Children's Intensive Care wing on March 5th 1996.

Five new paediatric intensive care beds were officially opened bringing the total number of paediatric intensive care beds at Guy's to 16, making it one of the two largest paediatric intensive care units in London. The Unit has already saved many lives, including two young children who survived meningococcal septicaemia over Christmas thanks to the pioneering work of the intensive care team, using a special machine (ECMO) which changes the blood to help clear the septicaemia.

The Paediatric Intensive Care Unit operates a Retrieval Service to collect critically ill children from other hospitals whilst providing continual intensive care on the journey. Last year the Unit collected approximately 200 children and expects that figure to rise substantially in 1996.

The Unit also supports the world leading services provided at the Evelina for children from many parts of the UK with a full range of specialities including kidney, lung, heart, metabolic and neurological disorders.

Her Royal Highness was introduced to paediatric Medical and nursing staff and members of the Evelina Appeal Committee. Over the past three years the redevelopment of the Intensive Care Unit has been one of the Appeals major projects which included the building programme, equipping the five new beds and setting up the Retrieval service. The total costs involved, £500,000 was raised by the Evelina Appeal and it was therefore a proud moment for all who had given so generously to see their efforts come to such successful fruition. The Duchess of Kent visited children and parents before joining staff and guests for tea in the Robens Suite.

The pleasure and warmth created by the royal visit was very much appreciated by us all and Her Royal Highness will be remembered with great affection by everyone.

Gazette Appeal

The gazette has been recently subjected a most unforgivable ordeal. Over a period of four or five weeks thieves have been at work at the Gazette Office, which is situated in Boland House, a building manned by a security guard 24 hours. Items which include a photocopier and a recently purchased fax machine were stolen separately on 2 different occasions. These items which were an integral part of the day-to-day running of the office are bitterly missed and are unfortunately not replaceable from our existing insurance policy. Other items stolen from other rooms in the same building include a desk computer and pieces of antique furniture. The Medical School's solution to the problem of security does not seem to have worked.

We are appealing to any of our readers who may be able to donate either of the two items mentioned, should they be in possession of equipment which may be unwanted due to age and model or surplus to their needs. If you may be in a position to help, please contact the Editor at the Gazette Office.

Philip Reading at 90.

A most distinguished Guy's man reached his 90th birthday on 16th January this year and so joined an extremely short list of Guy's nonagenarians. This was Philip Reading whom many of your readers will remember as a mainstay of our Ear, Nose and Throat department for 25 years after the war. During these years great innovations were being made in ear, nose and throat surgery with, for example, the advent of microsurgery of the ear and with the ENT. specialist taking over the management of head and neck cancer from the general surgeon. Philip Reading was responsible for introducing these advances into the ENT practice of Guy's - and much else besides.

(L-R: Standing. Sir Donald Harrison, Mr. Omar Shaheen, Mr. David Mathias, Mr. L.F.W. Salmon, Mr Philip Reading, Mr. C. N. d'E. Eastes)

A week after his birthday his daughter and two grand-daughters organised and prepared a celebratory luncheon at their lovely home in Alfriston, E. Sussex. It was an altogether delightful occasion. The house was packed and among the guests were four Guy's-trained ENT specialists, all of whom had in their time worked with Philip and learned from him.

Three of these were accompanied by their wives, also past members of the Guy's family.

The senior Guy's guest had achieved fame in a different branch of surgery however, genito-urinary surgery. This was F.R. Kilpatrick, known to everyone, then and now, as 'Kilp'. Like Philip, 'Kilp' had retired to Sussex, but to West Sussex. He brought with him his camera and took many delightful photographs, two of which are reproduced here. (Evidently someone else operated the camera for this one.)

Philip was in excellent form and coped with the throng just as well as he had done in the company of even more professional friends in the Robens Suite -- can it really be ten years ago?

Here it may be placed on record that every consultant member of the E.N.T. Department, since it was formed shortly before the First World War, has, on the occasion of his 80th birthday, been honoured in this way. The list to date comprises, in order of seniority: W. M. Mollison, T. B. Layton, R. J. Cann, Philip Reading and L. F. W. Salmon.

Perhaps it would not do to boast that no one has yet failed to make it.

Here is another Guy's tradition that must not be allowed to lapse.

(L-R: Lady Harrison, Mr. L. F. W. Salmon, Dr. Isobel Mathias, Sir Donald Harrison, Mr C. N. d'E. Eastes, Dr. Rosemary Hall, Mr. David Mathias, Mrs. L.F.W. Salmon, Mr Philip Reading, Mr. F.R. Kilpatrick)

L Salmon

The Hopkins Experience

In search of Hannibal

From all accounts, prior to my departure, I was letting myself in for 4 weeks of complete and utter torture. The verbatim floating around the mythical surrounds of the Guy's campus was something in the order of 'if the work doesn't kill you, the bullets will'. Hardly the most enticing compliment a hospital with the prowess of Johns Hopkins can be given but for many the only one fitting enough. The 'Gangsters' Paradise' as many now refer to it as, thankfully was neither rife with crime nor riddled with danger, however, the proximity of such was made obvious by the patrolling armed security personnel in the environs of the medical institution. This would seem somewhat a rather drastic measure here in London, but I feel highly appropriate in Baltimore, considering the location of the hospital. Fortunately, I have returned safely to tell the tale, and perhaps to offer more comforting words to those intending to go, than I myself received.

My first thought of undertaking this clinical attachment, was what a rather stupid name for a hospital reputed to be so great. And if you had asked yourself the same question, who could blame you? The truth is there are many students at the Johns Hopkins University who still don't know the answer. I wonder if this manner of ignorance is confined to our transatlantic colleagues? Indeed how many of our own flock know of our heritage? I managed, however, to decipher this conundrum, for those wanting to satisfy their curiosities, the hospital has been named after it's founder who was baptised with his mother's family name of Johns, his family name being inherited from his father, a wealthy philanthropist in his time. After alleviating my initial enquiry, I was prepared to face the challenges of hospital medicine in the United States.

The Phipps

The psychiatric services have been historically housed in what was at the time called 'The Phipps Institute of Psychiatry'. This world renowned building named after its benefactor had subsequently been rebuilt on a different site, and has been

incorporated within the hospital proper, as an adjunct building now called the 'Adolf Meyer Building'. Adolf Meyer was one of the forefathers of Psychiatry at the Hopkins and his immeasurable service to the hospital has been accredited in the same way as others in his class such as Osler and Blalock. Though the Phipps foundations have been torn down the tradition still lives on in a deep aura around the Meyer building. Psychiatrists of today continue to feel a sense of pride and dignity working in the psychiatric unit, the type of which has its roots originating at the old Phipps. Indeed the psychiatric notes of patients are still referred to as the Phipps notes and most notably the history which is taken from the patients when they are admitted, is known as the Phipps history. My first experience with the Phipps history was a rude awakening! I have never come across a written document which requires so much stamina on the part of the scribe. On admission to the in-patient service this 20 page document has to be completed thoroughly. Its contents, you may be wondering, are not that different to what is expected of us when we clerk patients in. However, the chief difference lies in the detail to which the Phipps history addresses. The doctor is entirely guided through the history and consequently there is very little scope for omission, indeed should anything be left out the burden of responsibility inevitably lies with the admitting doctor. It has to be said that much of the information required is not likely to be relevant to the particular admission but the justification for the formal Phipps history comes subsequently, perhaps years later when retrospective or cohort research studies are conducted. Immediately one can appreciate the usefulness of having a standardised set of notes from which to pluck data. However, at the time of taking, the only thoughts are those of 'what a chore'.

'My first experience with the Phipps history was a rude awakening!'

'Such thoroughness! Such organisation! Such a hospital! Well that is one way of looking at things...'

Such thoroughness! Such organisation! Such a hospital! Well that is one way of looking at things. Another would be to say, what wastage, what an overlap of resources. At the Hopkins, and I guess probably all over the USA, the *modus operandi* differs greatly from England. There is very much an emphasis on one person-one job, where as I'm sure you'll agree the converse is very much the norm

here. For a patient to be admitted to the in-patient ward he or she needs to be admitted by three different personnel. The resident working in the psychiatric ER (that's the A & E), which is separate to the main ER, will admit the patient. From there the patient needs to be re-admitted by a resident on the in-patient unit. Additional to this, the patient is required to be admitted; a history taken and management plan initiated by an Attending (Consultant) Psychiatrist. An excellent way of acquiring a complete history, I'm sure that there are many doctors here who have only discovered something about their patients through duplicate histories from the industrious student. However, useful, I feel this is highly impractical for the financial constraints of the NHS.

'Like a fool I accepted this burden as if it was something I had previously mastered at Guy's...'

Doctor before time

From the moment I arrived till the day I left I was delegated responsibility. Something which I had never been assigned before and something which I hadn't come prepared for. I was attached to a psychiatric in-patient team on Meyer-5, one of three services on the floor. The team consisted of the Attending, the junior resident and lastly myself. I was to be closely supervised by the resident and guided by the Attending. I was invited to share half the workload of the resident, well it wasn't so much of an invitation as an expectation, since this was the adopted practice of medical student training. For some strange reason I felt a flood of perspiration about to come on and the room temperature started to feel rather more than ambient. Like a fool I accepted this burden as if it was something I had previously mastered at Guy's and no sooner had I done so that I realised that my boyish charms were likely to be wasted here...at the Hopkins. My duties were to include clerking the patients in and performing thorough mental status examinations and more unusually, creating a management plan which was to include plans for discharge, whenever that was. The lack of use of generic names for drugs further compounded my

'I was invited to share half the workload of the resident, well it wasn't so much of an invitation as an expectation.'

already pathetic level of knowledge, and admittedly for the early part of my clerkship I was like a fish on land, dying. I would have to present the new patients in the 'formal Phipps fashion' is the phrase I recall, at the daily morning ward round which started early at around 8 o'clock in the morning. This seemed far too early for my liking but I was far too daunted by the prospect of lagging further behind, to care for more sleep. It was only when I discovered what time ward rounds for Surgery started (5.30-6.00am) that I was thankful for doing Psychiatry and not some other speciality. The morning round was the place I kept account of new developments with my patients (from the nursing report) as I was far too tired during the day to follow them all. Following the round, I would accompany the resident to the different daily activities, which would include Grand Rounds in Psychiatry, Neuropsychiatry, teaching rounds and so on. These proved to be very enlightening in many respects and also allowed me to see the greater organisation in post-graduate education at the Hopkins, than I feel we have on offer here. The highlight of the day was the 'free lunch'. Different daily lunch-time seminars were held, all with a common theme of eat, drink and be merry! The psychiatry residents, who would attend this can all be rewarded for their excellent taste in food, especially the Chinese lunch on Thursday!

'It was only when I discovered what time ward rounds for Surgery started (5.30-6.00am) that I was thankful for doing Psychiatry and not some other speciality.'

'The highlight of the day was the 'free lunch'.'

My initial difficulties soon passed by as I became more and more acquainted with the other residents and student. I use the term student in the singular here because I only ever met one student wanting to interact, and before you jibe, it wasn't because I was unfriendly! I also suddenly found myself becoming accustomed to being called doctor and more worrying, my initial hesitation in introducing myself as such, soon disappeared. Ethically, this was a bit of a dilemma for me as I felt that neither did I know enough to be called a doctor nor did I feel that I had earned that title and the respect that accompanies it. However, if by way of

my workload I had been credited with this status then it could be justified, and my conscience partly relieved.

Psychotics, Depressives & Manics

During my time on Meyer-5 I came across many different types of psychiatric patients, however, my initial thoughts of them being more dangerous and more psychopathic (the wonders of broadcasting media!) were soon put right. In fact I found that basically the cases were the same. Two cases in particular spring to mind; the first was a 48 year old woman who was admitted under emergency petition to the ER. She was noted to be hyper-religious, hyper-sexual and of labile mood. The patient had no previous history of any psychiatric illness other than a period of depression six months earlier. She refused to sign a voluntary certification and subsequently filed to appeal against her involuntary certification (section III equivalent). This meant that we had to apply to the courts to involuntarily admit her and then again to involuntarily medicate her. This entire process was a far cry from the relative ease with which the section III document is administered here. The time period within which all this was to occur was about 10 days. During this time we were allowed to keep her on the ward but not allowed to medicate her or force her to engage in group activities. This proved to be a very trying period for both other patients and staff alike. She continued to be hyper-religious, by preaching from the bible aloud before meals and not allowing others to eat until she had done so. She also appeared deluded on occasions, believing she was going to work. She would dress in appropriate business attire and carry a briefcase in to the day area. Prior to her depressive episode six months earlier, she was employed as a financial director with a large company. She was dismissed for illegally spending $40,000 on the company credit card. She manage to cause havoc amongst the staff by telling lies about them to others and she also managed to causes rifts between the staff and patients. In her own words she had 'become their saviour'. I was most impressed with this woman's intelligence, when she voluntarily requested medication after about a week on the ward. The following day was the day of the court hearing.

'...48 year old woman who was admitted under emergency petition to the ER. She was noted to be hyper-religious, hyper-sexual and of labile mood.'

The court hearing, which happened in a specially designated room within the hospital, proved to be an entertaining event. An official court Judge, the hospital Forensic Psychiatrist, the doctor and nurse involved in the patient's care, the patient, and an appointed advocate for the patient were all present. This truly brought memories of LA Law to mind. I was told beforehand that it is very rare for the hospital to lose. We presented the case for the hospital, which admittedly was very shaky, in view of the fact that the only violent intentions that the patient had demonstrated were prior to her ER admission. The judge then turned to the patient's advocate and asked her to comment. For the next hour I heard objection after objection in what was a very concerted defence for the patient. Extraordinary since, the patient and her advocate had only met just before the start of the hearing. At the end of it all the Judge delivered her decision, which on this occasion was in favour of the patient's case. She added that although clearly in need of help, by the law she was in no position to allow compulsory admission, in view of no history of violence. The patient wasted no time in showing her joy and we were left like the losing side in a cup final.

'Her belief was that she was being hunted down by the FBI.'

The second case was rather more amusing although equally alarming. The patient a 50 year old woman with a history of chronic schizophrenia, was suffering from delusions of persecution. Her belief was that she was being hunted down by the FBI. She was a difficult patient to manage, being refractory to most medication. Her level of hygiene is complementarily described as poor. Frankly she smelt so bad that staff had minimal interactions with her. On this one occasion she was thought to be of danger of deliberate self harm and consequently was placed on checks at 15 minute intervals. Prior to this she had been noted to be slightly hyper-sexual. Later during the same evening, the new nursing plan already in place, the patient contrived to make fools of the staff. In between her 15 minute checks she managed to slip out of sight of the nurses and entered the room of a male patient, one with which she was noted to have been to see earlier that day. The events which occurred within the room are likely to remain unknown, however when the nurses found her absent from her

'...they found her and the male patient engaging in sexual relations.'

own room and heard the groaning further along the corridor, they found her and the male patient engaging in sexual relations. This was deemed a serious violation of ward policy and earned the patient a stretch in the 'cooler' (isolation). My first reaction was obviously different to that of the nursing staff; what on earth possessed that man to do something like that with some body who smelt so bad? Then again I suppose anything goes when you're not *corpus mentis*.

Anybody for a drink?

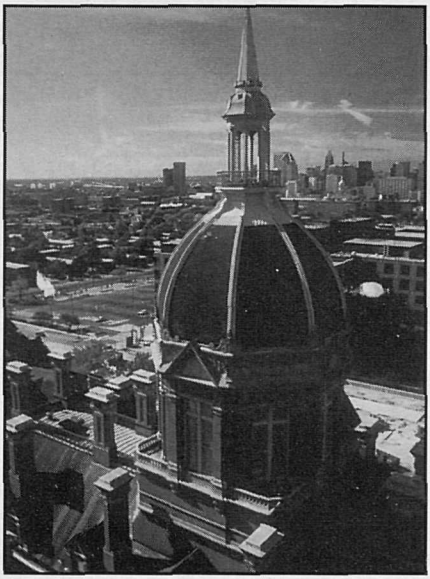
The simple answer to this question is 'maybe at the week-end'. Not the most social of people, in fact not very social at all if you refer solely to the students. The morbid pre-occupation with studying probably accounts for the majority of the hair loss amongst the students. The fact is that they are boring! During their first year at least, and I think for part of their second year, the medics there have a working day which starts at 8.00 am and finishes at 11.00 am. Yes that's right only three hours. So what do they do for the rest of the day? Sleep? Don't be ridiculous! They've much too much reading to do. How many of us can demonstrate such integrity? How many of us want to? The sad truth of the matter is, and I never thought I'd say this, I had more of a laugh socialising with the accountants, studying at the Homewood campus (Johns Hopkins University, main campus). I did however, manage to entice the nurses and residents into a night out, after much reluctance. This proved too much for some, whose abstinence from alcohol resulted in ADH levels lower than those accepted as normal even for the Oriental population. I was soon to learn the mighty disapproval of the senior staff the following day, when hangovers were had by most (especially the doctors), and my punctuality was noted to be slightly off, well okay I made it in for lunch. One thing that this made me realise was that doing Medicine as a profession in the USA is a lot more about competing than it is about surviving and getting by, something which has been echoed by many others.

Finally, my quest for Hannibal-the-Cannibal had come to an end. What started off initially as a joke became a concerted effort on my part to get to the truth. I'm still left bewildered by his actual existence...was he real? You will recall the infamous Dr Hannibal Lechter, the Baltimore Psychiatrist, noted to devour his patients with his own teeth, depicted in the Oscar winning film by Jonathan Demme, 'Silence of the Lambs'. It was him or rather his notorious past I was in search of, I was adamant about finding out more about him, since although having very little exposure to it, Forensic Psychiatry interested me greatly. Little did I know beforehand, but disappointment was to face me at every hurdle of my race

to find him. I spoke to many Psychiatrists and Baltimore locals, and scanned through library records, but was still left deliberating his existence. Half of the people confirmed the existence of a such a person having lived in the Baltimore area and the other people shrugged of my enquiry as if I were some foolish child about to play a prank. Perhaps it was foolish of me. Am I really losing my marbles, even thinking that he existed?

All in all an excellent clerkship at a hospital deservedly rated as number one. I highly recommend any students from here to make use of our special relationship with the Hopkins and undertake an attachment there - you will not regret it!

RT



'The famous Johns Hopkins Dome'

LADIES IN DEMAND !

Guy's Drug Research Unit (GDRU Ltd) are recruiting ladies who have undergone the menopause or who are sterile (that is, infertile or have been surgically sterilised) to participate in studies to test new drugs.

If you are generally fit and well and would be interested in doing trials, please contact our Recruitment Officers, June or Gloria on 0171 403 3756/7 (Mon - Fri)

The Guy's Hospital Staff Round: Case Reports

Trouble With Tuna

Two cases of scombrotoxin poisoning after exposure to tuna are described, the second being unusual in that tinned tuna was involved. This, not uncommon, condition may be mistaken for an allergic reaction. An important difference being that in scombrotoxin poisoning the symptoms do not recur on re-exposure to unspoilt fish.

Scombrotoxin poisoning occurs when certain fish, particularly members of the Scombroid family, undergo bacterial spoilage, with the conversion of free histidine in the fish muscle to histamine. About 50 episodes are reported annually in the United Kingdom. Small outbreaks involving up to five people are not uncommon.

CASE REPORTS

Case 1

A 45 year old male presented with a three hour history of face and throat swelling, flushing, headache and diarrhoea. The symptoms began about 45 minutes after eating cooked fresh tuna at a wine bar. His symptoms settled spontaneously after two hours observation and he was allowed home. The next day samples of the fish that he had eaten were obtained from the wine bar. Staff there said that three portions had been sold during the lunchtime concerned. They knew that at least one of the other diners had become ill. The samples of fish showed levels of histamine 200mg per 100g of fish. (Safe limit 5mg per 100g).

Case 2

A 31 year old male presented with a sudden onset of a red rash involving the face and upper body. It began about an hour after eating tuna mayonnaise sandwiches. The six other staff members in his office had also eaten the same sandwiches and became ill shortly afterwards, with symptoms including headache, flushing, rash and diarrhoea. All symptoms settled within a few hours of onset. Samples of the tuna mayonnaise were obtained the same afternoon, these showed levels of histamine 250mg per 100g. The tin which had contained the tuna had been opened about 6am in the morning, the tuna mixed with mayonnaise, and the sandwiches made and sold at about 1pm. Unopened tins of the same batch had low levels of histamine.

DISCUSSION

Scombrotoxin poisoning is also referred to as histamine poisoning[1] because of the central role that histamine plays in the condition. However questions still remain as to whether it is simply the histamine alone which is responsible for the condition[2].

The commonest fish indicated in outbreaks in the United Kingdom are tuna and mackerel, members of the scombroid family. However herrings, pilchards, sardines and anchovies have also been implicated. The first report of symptoms likely to be due to scombrotoxin poisoning was in 1828 when five sailors on the *Triton of Leith* became ill after eating atlantic bonito[3], another scombroid fish. All this family of fish have red meat, and very high levels of free histidine are found in the muscle. The free histidine is thought to act as a buffer to the large amounts of acidity produced by short bursts of activity. The imidazole side chain in histidine has a pKa close to neutral pH, making it an effective buffer.

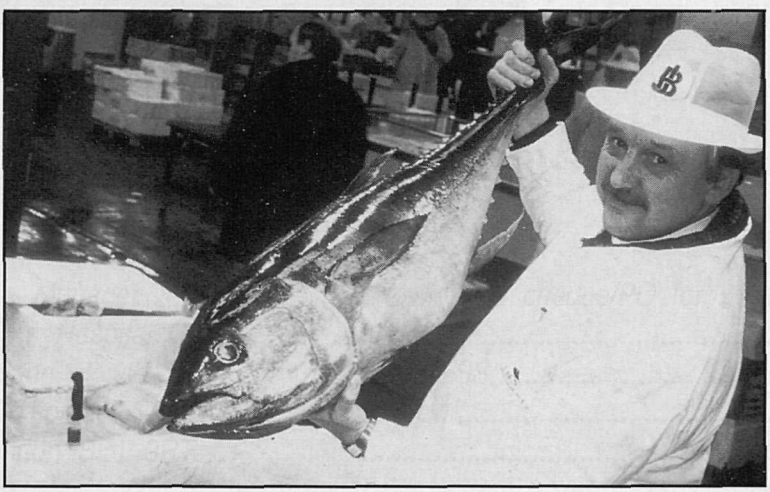
This free histidine can undergo metabolism to histamine by bacteria which contains histidine decarboxylase. This enzyme is not widespread, only some strains of certain bacteria contain it. These bacteria either contaminate the fish meat from the gut, or from handlers or the general environment. Fish that have been affected by these bacteria look and smell normal, however, they may have a peppery or hot taste. Histamine is stable in storage, and to heat. The conversion of histidine to histamine can occur at varying temperatures depending upon the bacteria involved, but will generally not occur with storage below 4° C. Nearly all cases of scombrotoxin poisoning relate to fish contaminated after catching or

in processing. However, contamination of tinned tuna after opening can occur in the right conditions, as appears to have happened in our second case. Cases of scombrotoxin poisoning have been reported throughout the world, but are commonest in the U.K. United States of America and Japan.

The onset of symptoms is usually within minutes to an hour or two of consumption and resolves within 12 hours. Common symptoms are flushing, rash, headache, diarrhoea and vomiting. Anti-histamines lead to a rapid resolution of symptoms. The exact mechanism whereby histamine reaches the circulation in scombrotoxin poisoning is not known, as pure histamine given by mouth is rapidly broken down by gut enzymes. If, as is usually assumed, the histamine in the fish is responsible for the symptoms, then some other factor must inhibit its breakdown in the gut, perhaps other amines. Another suggested mechanism is that a some other toxin in the fish is absorbed from the gut and causes endogenous histamine release, perhaps from basophils.

Conclusion

Scombrotoxin poisoning should be considered in any patient who suffers the typical symptoms after eating fish. it may be that many episodes are ascribed to food sensitivity, and the reported numbers do not reflect the true incidence of this condition.



References

1. Taylor SL. Histamine food poisoning: toxicology and clinical aspects. *CRC Critical Reviews in Toxicology* 1986;**17**:91-128.

2. Clifford MN, Walker R, Ijomah P, Wright J, Murray CK, Hardy R. Is there a role for amines other than histamines in the aetiology of scombrotoxicosis? *Food additives and contaminants*. 1991;**8**:641-52.

3. Henderson PB. Case of poisoning from the bonito (Scomber pelamis). *Edinburgh Med J.* 1830;**34**:317.

Ian M Stell,
Lecturer in Accident & Emergency Medicine,
Accident & Emergency Department, Guy's Hospital

Guy's Hospital MEMORABILIA

Unique items available only from the Gazette

Specially made, limited edition Guy's crested car badges. Grey background, black shield with silver lions, gold crowns and blue fleur-de-lis on. With the motto displayed on gold scrolls with black lettering. Frame forged in solid brass finished with deep chrome plate.

Price £25 each + £1 p&p

To: The Manager
Guy's Hospital Gazette
Boland House
St Thomas' Street
London SE1 9RT

I enclose a cheque/PO for £ .....
NAME: .....
ADDRESS: .....
.....
.....

Please make cheques payable to Guy's Hospital Gazette

Office hours: Monday to Friday 1-5 pm. Personal callers welcome.

The Housemans Review 1995

Once again the time had come when pride and dignity along with future job prospects were forfeited for the sake of humour. I'm sure you'd agree, humour is something that there is not much of outside the occasional operating theatre, and is always welcomed in the hospital environment. This is the time in the year that all the Guy's housemen look forward to, laughing at their superiors' expense. The event which was held in its traditional setting of the Harris lecture theatre, was again well attended with organisers having to resort to opening the balcony seating area (not often that that has happened).

The programme consisted of numerous small sketches accompanied by some never before seen video footage, which had been taken previously. The running theme this year, needless to say, was again depicting the fortunes or rather the misfortunes of a certain well disliked Trust executive, when an attempt to utilise NHS resources was made. One would have thought a well worn out gag, but not so as the audience rallied their support behind the juniors as they made the first of several points that evening.

The performance had much variety in terms of content as well as entertainment, and for me the pickings were the sketches about the Consultants and their favoured sports and the on-going sketch demonstrating that a porter's life is never done. The former was an excellent means by which the younger students in the crowd could choose their sporting preferences accordingly in order to ensure a healthy sign-up. In this gag the housemen dressed in fitting attire according to their respective Consultants former (and current in some instances) sporting prowess. The ever smiling figure of Dr Rees was funnily enough smiling, with bat in hand, in traditional cricket whites, whilst the ever youthful Dr Gibson was portrayed as the rugby player that he still is and also notable was the very life- like impersonation of Professor Gleeson.

The short sequences which could appropriately be called 'the moans and groans of the hospital porter' were very welcomed breaks from parts of the evening which proved unfunny, as the two porters would tell one another many tales from their respective working lives. The two junior staff had either had some work experience doing such a job or become very friendly with the portering staff (if that's at all possible, they seem to be the grumpiest people around), as they never seemed to leave the audience in anything other than hysterics with both their antics and their speech.

Other features worthy of a mention include the video footage of Dr Knight and his famous sandwich. For those who have never had the opportunity to cross paths with him, it would be fair to say that if they ask people who know of him, they are all likely to say one thing in common; Dr Knight has the most incredible manner in which he speaks and more so in the way he masticates. Whoever it was that managed to get him to agree to the filming needs some sort of Oscar, for this in itself was worthy of the 'Best Comedy Award'. Other features well worked included the Guy's tribute to 007, called 'Brownfinger' and the topical 'Bill and Bob medical phone-in'.

The evening was not with out its awards; the Dewhurst's Family Butchers Award for Orthopaedic Surgery being presented to a not so surprised Mr Nunn, the Bernard Manning Award for Gastroenterology being won by Dr Wilkinson and my favouirte the BSE Research Foundations Award for Neurology being awarded, uncontested, to Professor Hughes.

As always the performance was anchored by the traditional 'we hate the Government, we hate the Trust' type of song and as encouraged the audience participated, willingly. The evening's entertainment on stage was fittingly transfered to the Conybeare Club, for the off-stage party which in another of Guy's traditions was flowing with the amber nectar. This along with the stars of the night provided yet more opportunity for laughter and indiscretion and was a pleasant finale to the evening.

All in all an evening well organised and well participated and more importantly well enjoyed. This was equally well produced and equally popular as last years and is amongst the best for entertainment value. Well done and good luck to all who took part.

RT

Guy's Hospital - 250 years

Have you ever wanted to know more about the history of Guy's? What was student life like in the nineteenth century medical school? What happened in the Resident's Plays of the Forties and Fifties? How about nursing, midwifery, the Wills Library? Or the early days of X-rays?

This 240 page, illustrated paperback gives a history of the achievements in every field of Guy's life for the past 250 years, and is available for only £2.95, including postage and packing, from the Gazette office. The book makes an ideal gift, and only a limited number are available.

Please send cheques or postal orders, made payable to Guy's Gazette, to Guy's Hospital - 250 Years, Guy's Gazette, Boland House, London SE1 9RT

Guy's Hospital Gazette

English Pewter Goblets, Engraved with the Guy's Crest, available only from the *Gazette*, individually boxed. **Price £22+£1 p&p**

ORDER FORM

Name .....

Address .....

.....

Please send me . . . . . Guy's Goblets at £22+£1 p&p

I enclose a remittance of £.....

To: The Manager, Guy's Gazette Office,
Guy's Hospital, London SE1 9RT
Tel: 0171 955 5000 ext 5413

Personal Callers Welcome

Office hours: Monday to Friday. 1—5 p.m.

407 Art Club Exhibition

March 18 - 22 1996

Once or twice a year the club puts on a show to brighten gloomy old Hunts House. The Studio on the fourth floor may be aptly named but lack of light and space make it difficult to display the artists' work to advantage. Nevertheless, the show goes on and what a delight to see such a variety of material. There were a number of new exhibitors although students were again absent despite early poster appeals.

Amongst the newcomers was Margaret Flanders from the Gazette office who displayed three mounted batik prints. The large, colourful displays complemented adjacent paints. Different themes could be detected in the subtle patterns. These fabric creations demonstrated the versatility of the artists working on the Guy's campus.

Joanna Higgins was also new to the Club. She produced two small cloth designs of a garden and stars. Her watercolour of Blooms Restaurant was bright and nicely drawn, an attractive addition to the watercolourists on display.

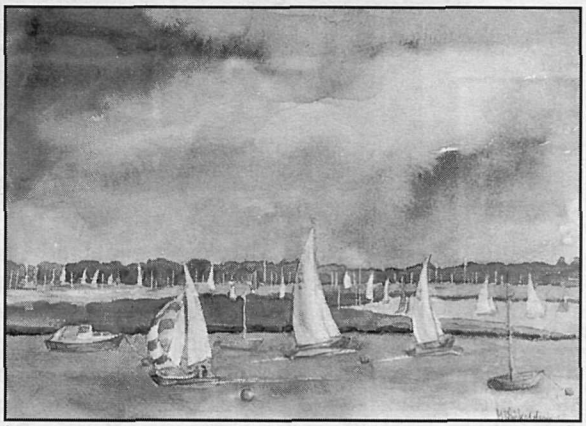
More by accident than by design one corner of the studio was occupied by animal figures. Michael Joseph's three illustrations of a donkey, an ostrich and a dog with a hedgehog were charming. These and Marion Knight's portrait of a dog called 'Phoebe' revealed fine draughtsmanship, a counterbalance to the abstract collage adjacent to them.

Matteo Adinolfi, as prolific as ever, displayed nine small collages combining plain and printed paper fragments, jigsaw pieces and other materials to produce a series of striking pictures, as enigmatic as their titles. 'May 3' was the most effective of these and comprised yellow and red paper with punched holes and a pattern of small washers. The mounting of

these studies enhanced their appearance. Matteo has real artistic flare and imagination and with more creative time at his disposal we expect him to continue surprising us with these exhibitions.

Another fine artist who has flourished after relinquishing a chair at UMDS is Roy Spector. His subtle watercolour washes of Moscow and Galilee were reminiscent of Huge Casson's pictures. A still life of tomatoes was more solid and colourful than the topographical scenes but still recognisably the work of the artist.

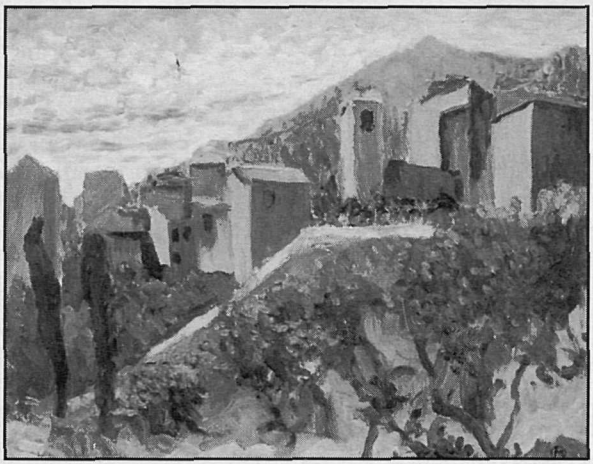
Other recent members of the academic staff whose pictures were on display were Cedric Mimms and Maurice Lessof. The former displayed five clever engravings. Those entitled 'Transformation of a foot' and 'The Flea' proved to be amongst the most popular exhibits. The latter artist showed three oil portraits, bold and colourful. The 'Yellow Guitar' was judged by some to be the most successful but all three displayed seasonable exuberance and vitality.



'Rousillon' was an oil landscape by William Mann, another regular contributor to these exhibitions. The style was unmistakable and similar to his studies of French scenes shown at earlier 407 Art Club gatherings. The careful use of warm colour and simplified shapes has an effect which recreates the atmosphere of southern France.

Sidney Leibowitz was the most versatile artist on display. A Watercolour 'The White Plate' was graceful and restrained. Two oils of tube passengers were equally well composed and executed. There was a still life lino-cut and a lovely garden scene with strong blue shadows and dark foliage. Some of the best work we have seen from Dr Leibowitz.

Terry Gibson made his usual contribution of watercolours. There were three views of Guy's from the Park, a street scene and two rural landscapes of Kent. The most professional pictures were those of Meg Dinkeldein who displayed four large water colours of closely observed features of Greenwich park, the Ardeche and Aldeburgh. These were technically outstanding paintings which could hold their own at any exhibition. A single watercolour of an iris by Susanna Nasskau revealed her superb talent, for fine, detailed drawing. This was a popular illustration and was sought after by viewers.



On this occasion there were two pottery stands. Jane Gibson displayed 18 pots, bottles and boxes. These were largely the products of wood and paper kiln firings, a technique for which she has acquired a reputation in the South East. Her knowledge and skill have been much influenced by pottery methods in South Asia an area whose pottery she has studied and written about. The smoked and cracked glaze effects she is able to create on classical shapes have a beauty which is distinctly her own. The other potter was Kristen Blay who was exhibiting for the first time. Her coloured domestic ware of jugs, pots and bowls were in contrast to

Jane Gibson's decorative ceramics. The group of seven vessels had a collective appeal and inevitably attracted prospective purchasers.

The exhibition was an opportunity for artists to enliven and brighten our lives if only for the short time it took to move around the small exhibition. To the perceptive visitor there was much to see and gladden the heart. We hope that the 407 Art Club continues indefinitely despite the uncertain future of Guy's Hospital. No matter that Hunts House will be demolished, the Hospital will simply have to find a suitable niche in the phase 3 block.

T Gibson

An Interview With Dr Robert Knight

The Physicians Role Model

Dr Robert Knight has been connected with Guy's Hospital for much of his life, first of all as a medical student, then as a junior doctor and eventually as a Consultant Physician. This has lead to a deeply ingrained fascination and love for Guy's which made him an ideal target for the Gazette interview team. No persuasive tactics or torture methods were therefore necessary to get Dr Knight to agree to the interview which took place in his office in Keats House.

Why and at what point in your life did you choose medicine as a career?

As a schoolboy I was always interested in the biological sciences as opposed to other subjects and my father, who was a General Practitioner in Wales, ran a single-handed practice from the family home so I came into contact with medicine from an early age. It seemed a fascinating subject. I don't think I ever considered anything else.

Why did you choose Guy's to train as a doctor?

My father trained at Guy's, I'd heard about Guy's and I had heard very little about any other medical school, so it seemed to be the obvious place to apply for. In those days it was rather easier to get into than it is now.

How did one go about applying for medicine in your day?

As far as I can remember, as it was a long time ago, you wrote to the Dean and asked if you could be considered as a student for entry in a particular year. I've

no doubt there were certain forms that had to be filled in, but it wasn't done in anything like the way it is done now.

Can you give us a picture of what Guy's was like in your days as a student?

It was very much smaller, of course. Geographically it consisted of the buildings that you see as you go into the front quadrangle, through the colonnade and around the park. There was nothing on the other side of Great Maze Pond except for what was known as 'The College' which was an old building damaged in the war where the house officers lived, and where there was a cafe known as 'The Spit'. Most of the activity was around the park. After you had been here a while you knew almost everybody because you bumped into people all the time. Now, of course, it's so much bigger which means that people work in various parts of the hospital so you never get to meet them. The other thing about it was that attitudes were rather different, people dressed rather better and the staff were more autocratic, everybody called members of staff 'Sir'. There was a great deal more formality between staff and students but there was a pretty cordial relationship as well. It was a very friendly place to be. I remember my student days at Guy's with great affection largely because it was smaller and you knew everybody pretty well.

Another thing that was interesting was that I came along very shortly after the war in 1949, so quite a lot of the students around at that time had been in the war and therefore were a lot older than those of us that came straight from school. In fact some of them were older than the teachers! This meant there was a mixture of young students and much older students which was actually rather good for us. The course was very different; there was the introduction to medical studies, the first MB in which you could do physics, chemistry and biology; then the second MB which involved physiology, anatomy, biochemistry and pharmacology. This was all done without any attempt to introduce any clinical subjects until you had passed second MB. Then there was what I would regard as probably the most useful part of the whole course, and one which I think is missing from today's medical course, and that was a full-time three months introduction to clinical methods which every student had to do. This involved the clinical tutor teaching all medical students who had passed their second MB or who had come from Oxford or Cambridge the elements of clinical medicine, ie how to take a history and how to examine patients. This was done in what was called the pre-clinical classroom in the top of out-patients. Students examined each other, after which a whole panel of patients would come up, who the students used to practice on. All the systems used to be taught very thoroughly. The clinical tutor when I did it was

Dr Houston who of course became Dean. He was a marvellous clinical teacher and when people of my vintage finished the introductory course we were really quite experienced at examining patients. I think that a full-time introductory course is probably the feature which is missing most from the curriculum now. After this we would spend periods of three months as ward clerks or dressers with firms which were pretty large; there would be junior students who were just starting and senior students together. This meant that the junior students could learn quite a lot from the senior students on the firm. There were at least three medical firms and three surgery firms, so we did a lot of clinical medicine and clinical surgery but of course in those days there weren't so many specialist subjects to be covered and there was also a great many patients to see both in out-patients and on the ward. Now-a-days the firms are much smaller, which is a good thing, and students go off to other hospitals to see patients.

It has been said you were not adverse to a joke or two while at medical school. Can you expand on this for us?

Well I can't think who could have said that. I thought I was a model student! I was keen on rugby and as you will know when you start playing rugby, you sometimes fall into bad company. When I came to Guy's I was still young and I was a teetotaller, I didn't even like beer, but it soon became clear that when you played rugby, especially with older people, on Saturday evenings you were expected to drink beer. This meant that some of these evenings were a bit lively! Perhaps this is what your question is referring to.

How do the students of today compare to you and your contemporaries of yesteryear?

I don't think some of the things can be printed! Seriously, quite a few of my contemporaries were older than me and were married and some even had children. There were very few girls; in my year I think there were about ten. Students in my day were probably not as serious as students are now. I doubt if they worked as hard as students do today, but students now have so much more to learn. I think that on the whole it is hard to compare generations in this way. There were plenty of hard working, bright students then as there are now but one feels that they came from rather a different background. I find it rather difficult to compare them frankly.

Can you give us an outline of your postgraduate career in medicine?

Like a lot of people in my generation, having done my house jobs at Guy's, I then went into the army. I spent a few months in this country and then I went to Libya where I worked in the British Military Hospital in Tripoli. Part of the time I was sent out to become medical officer to a cavalry regiment in a remote posting on the North African coast. I also spent several weeks in the Libyan desert on exercises. Although it was a fascinating and very enjoyable time there wasn't a great deal of medicine to be done because one was looking after healthy soldiers and their families. This meant that I was able to spend a lot of time lying on the beach outside Tripoli. When I returned to this country I had to then learn some of the medicine that I had forgotten. I went to the Whittington Hospital as a house physician in general medicine and neurology. Then I went to the Brompton Hospital for six months which was tremendously good fun and very interesting. I then returned to Guy's to work with Professor Butterfield in the Department of Medicine where I spent a year working along side Harry Keen. We worked on a method of measuring the blood sugar in people who sent dry samples of blood on a piece of blotting paper and I also did work on blood flow in the feet of diabetics. I then passed the MRCP and became a junior registrar and then an ordinary registrar at Guy's and in 1962 I became a senior registrar and went of to the Johns Hopkins which was very interesting. During that time Sir Roland Boland who was the Dean, arranged for me to have a fellowship which enabled me to travel around the United States looking at the way that they teach medicine in their medical schools. I then came back and spent two years out in the region, first of all at Bromley Hospital, then at Farnborough Hospital which was the rotation that senior registrars did in those days. I returned to Guy's in 1965 and became a clinical tutor in 1967. At that time one had honorary consultant status and soon after that I started to look after patients at St Olaves Hospital. Finally, in 1970 I joined Dr Houston on a firm at Guy's and I've been here ever since.

What are your views on Calman training?

My training career was a very opportunistic one and also a very long one which was typical in those days. I think Calman training is going to be very good for medical staff in the sense that they will get a more formal career and a shorter period of training. It is going to be very difficult to organise because someone will have to do the work and if there are fewer junior staff around for shorter periods of time then there will have to be more consultants to both train and do the clinical work involved.

What have been your most satisfying experiences as a doctor?

I suppose what I've enjoyed most is working with colleagues who I like and admire because in a place like Guy's one is very lucky to be working with a large number of very bright and able people and that has certainly been a really marvellous experience throughout my clinical life. I enjoyed being in the army because it enabled me to travel and see things I otherwise wouldn't have seen and I enjoyed visiting the States. The most satisfying experience is simply the contact with interesting patients and lively students.

During your time as a consultant at Guy's you have become renowned for your tours of the hospital to the medical students on your firm. Can you tell us what these tours involved and how did they come about?

I've taken the view that students who work at Guy's ought to be familiar with its history and there are certain things about its history which are unique and to my mind very important. Therefore, I have made a point of taking students to see what I think are the really important historical aspects of Guy's. What I've tended to do is take the students first of all to Borough High Street and show them where it all began which was at the south end of London Bridge where a community grew up requiring care leading to the monks of Bermondsey building a hospice which became St Thomas' Hospital. Then I bring them round into St Thomas Street to show them the door through which students passed when moving between St Thomas' and Guy's for lectures. After this I point out the various important features in Guy's itself. My particular interest has been in the Gordon Museum where I introduce them to the three great physicians of the last century, Addison, Bright and Hodgkin who brought such distinction to Guy's. I show them the objects which are so unique to this place, that is the specimens in the museum of Bright's original kidneys, Hodgkin's original lymph nodes and Addison's original adrenal glands.

Do you think the former Secretary of State for Health was showing early signs of Mad Cow's disease when she decided to transfer inpatient services to St Thomas'?

I wouldn't like to comment on the former Secretary of State's mental health! I think she was influenced very considerably by her civil servants. The decision made by the government in collusion with the Trust Board, the local health

commission and the local health authority was a mad one and a perverse one. Guy's and St Thomas' united as a medical school twelve or so years ago and that has been very successful but the union of the two hospitals was never going to be easy because the aim of the medical school is to be a single excellent medical school whereas the government's aim in uniting the two hospitals in a single trust we now know was to close one of the hospitals. Neither the staff of Guy's or St Thomas' can be expected to co-operate in this idea. What has happened is that a decision has been made which will reduce Guy's to a large outpatient department which threatens to destroy some of the best departments in the trust which have world class status and have taken many decades to build up. For example, Neurosciences, which outside advisers said should not just be within the trust but at Guy's, has been moved out of the Trust altogether to King's in order to try to bolster the future of the Maudsley. That's a crazy decision and it isn't working very well. Similarly, the paediatric specialities at Guy's, which are equal to if not better than Great Ormond Street in many respects, to some extent because they are associated to adult specialities of a similar kind, are seriously threatened by some of the decisions which have been made. That would be a tragedy if they suffered. Renal services, cancer services and cardiac services had been expected to thrive in the integrated Guy's which would have been complete upon the opening of what was called Philip Harris House, but are now all to be stuffed eventually on the St Thomas' site which is too small. It is going to be extremely expensive to try and accommodate all these specialities there and this will leave New Guy's House and part of the Tower empty and Philip Harris House used to a large extent for purposes it wasn't designed for. So the government has made a decision which looks mad, it's going to be extremely expensive, and which doesn't take into account the needs of the local population. It's a decision which should be modified; a more flexible approach is required. I think that they will suffer as a result of this decision and some of the others that they have made.

Do you think Guy's has a future?

The future of the medical school is secure with Guy's, St Thomas' and King's but we would like to see the hospital playing a bigger role. I don't think any of us want to see St Thomas' future threatened but we would like to see more in-patient clinical activity at Guy's to make it a more comprehensive clinical unit associated with the medical school. I hope that in the course of the next few months or so, sense will prevail and a more flexible approach to the planning of the two hospitals will emerge. If that does happen then Guy's has a very distinguished future. If it

doesn't happen I think that there are going to be years of chaos and discontent because the present plans will not work.

What are your views on the proposed merger of UMDS with King's?

A sense of inevitability I suppose because I think there have been plans for some time within the University of London to have four large centres in the four quadrants of London and so this meant that logically in the south-east quadrant the three elements would join together to form a large single school. I think this will probably be very successful in due course.

Can you tell us anything about the history of the gazette and how you came to be the Chairman of the Gazette Committee?

The gazette was first published in 1872 and was originally a hospital journal although it's always been edited by students. When the health service was reorganised in 1974 and health authorities started to appear it became more closely associated with the school and has remained as such. It has always been and continues to be a journal edited by students, for students and former students, so it reports current activities and also interesting articles for the benefit of former Guy's people, nursing as well as medics and dentists. Because it has a significant financial implication and because there are managerial matters which have to be dealt with, the gazette committee was originally appointed by the governors of the hospital to oversee the running of the gazette and to make sure that it didn't get into any financial difficulties. The committee has a chairman whose appointment is now made by the medical school rather than the hospital and whose job it is to ensure that nothing is printed which will bring the hospital into disrepute. We've been very lucky over the years as we have had a large number of highly talented editors who have continued to produce a gazette of very good quality. There are times when they cannot be expected to know the significance of some of the material which passes in front of them and every now and again something crops up which might be rather delicate and so an informal relationship between the Chairman of the Gazette Committee and the Editor exists to help avoid any elephant traps of this kind.

John Davies

Handbook of Current Diagnosis and Treatment

This book which comes in two forms, both as a handbook (though not small enough to fit the tight constraints of the white coat) and as a sturdy desk companion, in its hardback edition, at first glance seems the ideal resource for those keen on 'list learning'. The book falls into the reference class of text books as its contents resemble more an encyclopaedia of medicine than an integrated text. Basically, this book attempts to relay all the relevant information across a double page, with headings such as signs, symptoms, investigation and treatment. All the necessary information one would require in the follow-up of the patient. However, where it fails is in the fact that the book makes no attempt at connecting different illnesses, i.e. there is little mention of known associations with other diseases or syndromes. From the point of view of the theoretical student this is a problem. So in essence you are equipped with adequate practical guidance but are less informed about the illnesses to which the management plan is to be implemented. For those thinking of purchasing a book of this category, this probably is not the one to carry you through finals. (**Handbook of Current Diagnosis and Treatment, Ponder & Hamilton, Churchill Livingstone, ISBN 0443056005, £19.95**)

S YPatel

The Clinical Manual

The first impression this handbook leaves you with is one of an excellent alternative both in size and content, to the Oxford handbook of Medicine. When you delve in to the text you realise that in some respects it is far superior to its contemporary. In particular the sections on history taking, examination and investigations are far better than the respective sections in the Oxford handbook, which are scattered throughout the book. The investigations chapter is especially thorough and covers both the common and less common tests as well as demonstrating the hallmark changes or lesions which result from pathology. It is only expected that to be so thorough in some aspects would result in neglect to detail in others. This is all too apparent when the bulk chapter of the book is examined. This chapter which outlines the diseases and their characteristic

features really focuses only on the common ailments. So much so that one could read through the section on any system in a matter of a few pages. It is hard to say whether this is good or bad since students are consistently being told to concentrate on what is common, but my feeling is that this lack of breadth will probably discourage a large number of students from purchasing an otherwise excellent book. All in all I have no hesitation in recommending this handbook, especially to the students recently introduced to the clinical course. (**The Clinical Manual, Bradley, Rubenstein & Wayne, Blackwell Science, ISBN 0632033126, £9.95**).

SYP

Glassware

The Gazette is now in a position to offer customised crested glassware to interested readers. Currently we have crested paperweights which make ideal reunion or anniversary gifts with your specific dates printed with the crest. The custom designed paperweight costs approximately £4 each and are made to order. So, if you have a special ocassion in mind why not contact the Gazette and place your order.

THE FAIR SEX or FAIR PAY?

I was quite amazed when I heard the news: nurses to receive 2% basic pay rise, whilst all other public pay employees were going to get more! I can only assume that it was the recurrence of IRA bombing that prevented nurses taking to the streets in protest, or, as they may yet do, propose strike action. The pecuniary concerns of those at the upper echelon of hospital management are considerably more well looked after than those at the hard end dealing with patients and clearing up the shit.

Alright, no one doubts the massive responsibility held by those who manage trusts within the NHS, but bearing in mind that they get much larger salaries to start with, why should their percentage increase be so much greater?

Furthermore the increase needed to give nurses more than 2% must be funded out of savings made by individual trusts - in other words - for nurses to get a decent pay rise patient services must suffer further. Already many nursing posts have been lost, and the employment of lower paid care-workers has replaced professional nurses; while I am not suggesting that these unqualified staff do not do their best, it is inevitable that their on the job training cannot replace the knowledge offered by fully trained nurses.

Every year there seems to be a problem about finding the money to pay nurses properly. The Review Body was set up to prevent this confrontation, but it now seems to connive at Government plans to create local pay bargaining over and above a basic level.

Some trusts have gone for 'bribery' by offering starter sums of a few thousand pounds to encourage recruitment to areas where is a dramatic shortage of staff. This can only aggravate the situation where there are national shortages, and we will continue to see shortage of nursing staff. This can only aggravate the situation where there are national shortages, and we will continue to see shortage of nursing staff, with consequent bed closures, that have resulted in patients who are acutely ill being transported around the country until appropriate care is found for them.

The shortage of recruits into nursing is already being noted; this will filter through to the service in due course. The difficulty experienced by nurses who are already in service to obtain a good salary is only going to exacerbate the problem of staff shortage.

There are many stories circulating of nurses taking on second jobs to enable them to get a reasonable standard of living; some of these are more legitimate than others. Yet other nurses, are working via 'bank' or agency to supplement their incomes; this may mean

that they are tired, and may not be functioning at their best.

There is, no doubt, going to be a lot more heard from nurses about this insult to their professionalism, when compared with pay offered to medical and dental colleagues. Once again it would seem that the Government has regarded nurses as an easy touch; one cannot help thinking that this may have something to do with the fact that the majority are female. Indeed in conversation with some married nurses it soon becomes obvious that money is not so high on their agenda when they are not the sole income earner. Nurses must demand fair pay for their work, regardless of such considerations, and they may need to take a stern line with the Government to achieve this.

Denis Cobell

Back Issues

Back issues of the Gazette are availabe from the Gazette Office at a cost of £2 +p&p. There are limited copies of most of the previous issues.
Please contact the Office with your requests.

IAN HENDERSON

Ian Henderson ERD, MBBS, FRCS (1918-1995), known to his Guy's friends as 'Granny' was born in Hamilton, Scotland, into a well-known Perthshire family noted for its military and academic achievements. After education at Fettes' College, Ian entered Guy's in 1937, having won a scholarship. He graduated MBBS., in 1943, after holding student House appointments to Lord Brock and Mr McNair at Guy's and Mr Miles Phillips in Carmarthen.

From 1945 - 1947, Service in the R.A.M.C. took him to Northern Ireland, and the area then known as the North West frontier. The beauty of the latter made a deep and lasting impression. He left the RAMC. after holding the rank of Major, and returned to Guy's to pursue his ambition to practice surgery. After holding House appointments, Ian became a Demonstrator of Anatomy at the medical School in 1949. From 1950 - 1956, after becoming a Fellow of the Royal College of Surgeons, he was Surgical Registrar to Mr. W Ferguson (a Guy's man) at the West Middlesex Hospital, and Senior Registrar to Professor Ian Aird at Hammersmith Hospital. He was proud of these Appointments and spoke of them in glowing terms.

In 1956 he was appointed Consultant Surgeon to the Tunbridge Wells Group of Hospitals, until his retirement in 1982. He was honoured in 1971, by his appointment as Honorary Physician to HM The Queen's Household and the award of ERD. Ian retained his interest in the Army. He joined the Territorials and was instrumental in establishing 308 General Hospital (TA). He attained the rank of colonel and was TA Vice President.

Ian was a man of high and strongly held principles, which he would defend vigorously. Once he had dug his heels in on what he believed important, he was impossible to budge. Never impulsive, his actions were well thought out. His principles strongly influenced his professional ideals. He gave his best to everything he did in his teaching and the welfare of his patients. These principles brought occasional brushes with lay administration, but he would never surrender on a matter of principle.

After taking early retirement, he pursued his lifelong interest in classical and biblical archaeology. This lured him into remote corners of the Middle East. As he did nothing by halves, he acquired a profound knowledge of his hobbies.

Granny was a keen sportsman. He played rugby during his student days, often in the company of the writer of this note. As a three-quarter he had a safe pair of hands, which endeared him to us hard working forwards. He was a keen supporter of the Guy's RFC. and a life member of the Clubs Union. He was also a skilled skier and golfer,

which sports he continued when he was no longer able to chase the oval ball. He was endowed with a fine sense of humour and enjoyed teasing and be teased.

Ian enjoyed a happy marriage with Rosa Hertz, an obstetrician and gynaecologist, who he had met while they were serving in the RAMC. at the BGH, Quetta (now in Pakistan). They married in 1951; had two daughters, the older of whom trained at Guy's and is in General Practice in Hertfordshire. There are two grandchildren. Ian died suddenly in the early hours of 7th November 1995. Our sympathy goes to Rosa and the family. He will be missed by his circle of friends, all of whom will treasure memories of a skilled and dedicated surgeon and a man of high principles.

PG Large

Elideah Kilpatrick

Kilpatrick,E- Died on December 16th 1995, peacefully after a long illness. She was the darling wife of F.R. Kilpatrick 'Kilp', and loving mother of Bruce, Fiona and Stewart.

In the 1930s Eileadh qualified as a radiographer and worked at Guy's and subsequently at Putney Hospital.

FR Kilpatrick

Notification of Deaths

The Gazette makes no charge for publishing notices of deaths or obituaries. If you would like to have such a notice included about a former Guy's affiliate, please send in either a typed copy or clearly written copy of the notice. We request that all obituaries should be typed or word processed.

NEW SUBSCRIBER
BANKERS ORDER SUBSCRIPTION FORM

Photocopies are acceptable

Please return completed form to:

Guy's Gazette

Boland House
Guy's Hospital
St Thomas' Street
London SE1 9RT
Tel 0171 955 5000 ext 5413/5414

To the Manager

_____ Bank plc

_____ Branch

_____ Address

_____

Please pay the sum of £15.00 annually on _____
commencing 19____ to the credit of:

Guy's Hospital Gazette
Account No. 80401269
Midland Bank plc
Southwark Branch
28 Borough High Street
London SE1 1YB

and debit my account accordingly:

Name (please print) _____

Account No. _____

Address _____

_____

Signature _____ **Date** _____

Football

UMDS 1st XI Season Report

The season started off in early September and things looked promising for the club. An injection of fresher supply strengthened the second and third XIs and if it were not for them we would have struggled to get three teams out.

As usual the first XI had a mixture of 'old boys' and students as a purely student team was not deemed to be strong enough to compete at the highest level. However, this poses immediate problems-the team on Saturday and Wednesday differ all of the time and we didn't put out the same team on a Wednesday as we did the previous Saturday.

Having been relegated last season, promotion back to Division 1 was the top priority. As the first couple of games showed, with wins of 5-1 and 5-1, we didn't belong in this division. The UAU competition always starts early and as usual we did not do well. This was hardly a surprise as we were grouped with other university 1st XI teams such as Goldsmiths and LSE, who play in the Premier Division. These matches were therefore used as training session, so the team could gel.

As the season progressed it was obvious that it would be difficult to get a decent side out as the better players were in the latter years or had already qualified. Persuading these people to play was the hardest part of captaincy but when they did play a ten-fold improvement in performance was seen, a 'Cantona type of inspiration' if you like.

In the cup competitions (UH and UL) we drew KCH and convincingly put them out of both cups with wins of 5-0 and 2-0. These were early signs that this season we would perhaps come away with some silverware.

By Christmas we reached the third place spot in the table and were poised to pounce when the season resumed, with games in hand over the big teams. On the cup front we were timely dismissed from the UL cup by UCH and were facing an equally likely outcome when we played our opponents in the semi-final of the UH cup, Charing Cross. At this bitter clash, we were victims of our own misfortune as failure to put away chances and sloppy defending resulted in a crumbling of our resilience and we fell 1-3 at the hands of our satisfied opponents.

The focus of the remainder was now the promotion and title race. Half-way through and we found ourselves sitting at the top of the table. This in itself was testing for us as everybody wanted to get a point or more out of us and consequently a few harsh challenges were felt, which otherwise may not have occurred. Nearing the end, we had the title in our sights and we made sure that we won our last five matches. However, our arch rivals in the race, KCH managed to rearrange a game in which they

had already conceded the points, in order to pip us at the post. They were set to play KCL II in the last game and if they won they would've had the title over us by 1 point. Funnily enough they managed to win 9-2. Though we protested to the authorities about this illegal endeavor, it appeared that the beaurocrats favored the opposition and UMDS were again robbed by ULU officials.

So we finished second, didn't win the title but did get promoted back to where we belong, but unfortunately there are no prizes for second best! Thankfully we managed to wind down during our Easter Tour of Amsterdam.

C Eldridge

Cricket

A Review Of The 1995 Season -

UMDS 1st XI: P21 W9 L 9 D 3
UMDS 2nd XI: P1 W0 L 1 D 0

The season commenced with the annual tour to Oxford which inevitably saw the first defeat of the season, not totally unexpected after the carnage from the night before. Tours after all are all about team bonding and not winning, as the epic Devon tour was to prove.

Early season matches saw two more defeats both by 1 run.'Special Needs ' (Mike Lewis) decided that with 1 run needed off the last two balls with the last pair at the wicket, that the best approach would be to wield his 'excalibur' and attempt to hit the ball back to central London - he failed. No need to mention what the ball hit. On an encouraging front the match saw new boy 'Zeb' (Dharmesh) make 59 and Sanjeeva 'I can only bowl well in my second spell' Wickremasinge and 'Dougle' (Arun) take 4 and 3 wickets respectively. The following match was lost in similar fashion but with Vince taking over the role of Special Needs.

The first victory of the season came just at the right time, the 1st and only round for us in the UL Cup (the quarter and semi-final draws being very favourable). The victory was set up by a brilliant, opening stand of 114 by Joe 'Token Fresher' Jacobi (63) and Dave 'Team Man' Simcock (49). Post match celebrations saw a very grinned and ecstatic skipper Billy 'Which sport can I take up next?' Jowett, explain to all present, how much he loved them all and how UMDS will win the UL Cup and the UH Cup and the Benson and Hedges, Natwest Cup and of course the World Cup. Well he had a dream! Matches leading up to the UL Final saw Billy take 6 for 46. Sanjeeva 6 for 39 and Joe 51. Unfortunately none of this rubbed off on the final. The less said about the Royal Holloway pasting the better except a good analogy would be this year's world cup match; Sri Lanka 398, Kenya not 398! (although a

scourge by Simcock got Sculleyof a respectable score.)

The match against the Dr. Rees' XI saw a fine victory, with James 'Fake Oakleys' Gossage finally turning up almost in time and getting some runs (45) and BSc. Belliies (Mahesh) ruling out any chance of a Guy's house job taking 5 wickets including Fr. Rees first ball.

The quarter-finals saw us win a rain affected match against The Royal Free twice under a little controversy. The first match saw Dave scoring 68 and Jules 40, but the match was abandoned (unlucky boys, doesn't count in the averages!) and the second saw us needing only a further 78 runs off 34 overs with 8 wickets left. We were worthy winners. The following match saw us thrashing Barts with a spectacular batting display by Guy Thwaites (99) and Dharmesh (102). Unfortunately the performance was a match too early as three days later in the semi-final of the UH Cup we lost to the same team thanks to minor pre and post tea collapses.

The match against Prof. Burnard's XI was almost called off due to 'glass on the pitch' following the ball a few days later. Thanks to the groundstaff and members of the team and a few cut fingers the game was given the go ahead. UMDS plundered a large score Vijay 63, Guy 50 and Dharmesh plus fractured cheekbone 47. The match was in UMDS' hands but thanks to some rather generous bowling the match slipped away. Billy and his fellow pie-bungers learned very well how to watch the ball all the way to the boundary.

The highlight of the season was undoubtedly the tour. It started with a win at Cobham and everyone staying the night at Cobham (thanks to Cathy and Silas). Well, not everyone. Simcock mysteriously missed the minibus in the morning, but he was there in spirit in the form of his bat, which was much appreciated. How we got to Yeovilton on time the following day was a miracle considering the various amounts of stomach contents that decorated Cobham the previous night. Tour names were initiated at Cobham while people could think, we got as far as four before thinking stopped! Magic Roundabout was the theme. Dharmesh was 'Zeb' for some athletic fielding, Anjay was 'Brian' for not so athletic fielding and Arun was 'Dougle,' for reasons 'out there' nothing to do with cricket. Jules for some odd reason wanted to be known as ' ---- rhymes with Prat' a name which even his father found amusing that evening.

Performances on tour were on the whole pretty dreadful. Although Joe must be mentioned for scores of 57, 31 and 63 and also James 40 no and Sanjeeva 51 no for saving the game against Blundel's School. Of course Brian (the opposition also started calling this, furthermore, he began introducing himself as such) must be mentioned for a superb hard hitting 72 against

...UMDS! He single handedly won the match for the opposition after being dropped from the team and subbing in for a missing player at Lynton and Lynmouth. Non cricketing highlights were Billy and Dougle's £80 furniture removal from the hotel patio; Steve's Hotel and his help yourself at the bar but write it down on a piece of paper; and 'Special Needs' and his bestest friend in the world, Robet Louis Stevenson, the inventor of steam who always bins his mates! Mike you were a cause for concern that night! A special mention has to be made of Jon Jones as the only member on tour not to have had an intimate chat with the large white telephone. Four matches were played after tour all of which were won, its amazing what tours can do. They saw the return to form of Dougle who claimed 16 wickets in three matches.

This season we hope to continue what was started last season, a good team spirit and the use of a large squad which will be helped by the existence of a Second XI this season. This is even more important this season with the large number of fixtures, including entry into the BUSA league. Two beginning of season tours to Oxford and Cambridge should see a fun start to the season with the annual trip to Devon mid-season and a prospective trip to sunny Guernsey to round things off. In between is the serious business of the two cups for which a bit of support would be mot appreciated. An afternoon out in the sun having a bit to drink is not that bad, it beats work!

If interested contact:
Mike Lewis 0171-587 1030
Dharmesh Misty 0171-928-0954

D Mistry

Calling all September '73 Set

Several members of September '73 Set will be attending the celebration of the last Guy's nurse at Guy's on Saturday 11th May and the Gala Reception in the evening. Do try to attend. Other contemporaries are also welcome to join our party. Contact Alison Thorne (nee Healy) or Michelle Bramfitt (nee Scott) on 01730 825688 or Hilary Kitson (nee Trease) on 01629 583681. Tickets are available direct from Nurses League

10th Anniversary Dinner

It is hoped that a reunion dinner/week-end will be organised for later this year in September, for those people who qualified in July 1986, as part of the 10 year anniversary. Those ex-students who would be interested in such an event are asked to write to Mr Chris Barry, Department of Gynaecology, Southmead Hospital, Bristol BS10 5NB, or e-mail Compuserve 100105, 1736

Partnership For Sale

Kingsbridge, S. Devon

An unexpected opportunity has arisen to practice in a busy market town, close to the sea, within a thriving rural community. I have to retire, reluctantly, due to ill health.

Busy practice - predominantly private - delightful patients. Excellent co-operation between both partners and local dentists and doctors.

Good schools. Recreational facilities include three golf clubs, theatre, music and arts, river and sea fishing, boating, cliff and moor walking.

Ideal for the family life - away from the rat race!

C. Keith Millman M.B.E.
11 Mend Lane
Thurlestone
Kingsbridge, South Devon.
TQ73PB
Tel 01548. 560788

Changing Your Address?

Please give us SIX WEEKS' NOTICE of your move. This will help us to make sure your *Gazettes* continue to reach you.

PRINT YOUR NAME AND **OLD** ADDRESS	NAME
	OLD ADDRESS
	POSTCODE
THEN PRINT YOUR NAME AND **NEW** ADDRESS HERE	NAME
	NEW ADDRESS
	POSTCODE

Now cut out this coupon and send to:

Guy's Hospital Gazette
Boland House
Guy's Hospital
London Bridge
London SE1 9RT

GUY'S

HOSPITAL GAZETTE

UMDS Guy's
1996
Library

June 1996

- Interview with Dr Andrew Warren
- Guy's Hospital Staff Round
- Nurses' League Commemoration Day

Guy's Hospital
MEMORABILIA

Unique items available only from the Gazette

Hand painted Guy's crests mounted on a selection of woods. These make ideal gifts for any Guy's man or woman. Just what you need to decorate your surgery or study!

Price £25 each + £1 p&p

To: The Manager
Guy's Hospital Gazette
Boland House
St Thomas' Street
London SE1 9RT

I enclose a cheque/PO for £ .....
NAME: .....
ADDRESS: .....
.....
.....

Please make cheques payable to Guy's Hospital Gazette

Office hours: Monday to Friday 1-5 pm. Personal callers welcome.

CONTENTS

194 Passim
196 Letters—Guy's London? Dental defence
197 News—Precision surgery, New Clinical Dean
199 Feature—Interview with Dr Andrew Warren
207 Feature—Reflections and hopes for General Practice
216 Feature—Guy's Hospital Staff Round
222 Feature—Guy's Nurses go out in style
225 Reviews—Surgery, Histology, Microbiology
227 Nursing Notes—Holy Hearts
230 Obituaries—Terence Finnegan
231 Clubs Union—GradSoc
233 Sport—Rugby, Football, Hockey, Sailing
240 Classifieds

UMDS Guy's - 1996 Wills Library

Guy's Gazette

Editor Rikin Trivedi **Assistant Editor** Paul Hayden **Sub Editor** Sue Ferguson **Features Editor** Kate Mundray **Review Editor** Susan Jain **Sports Editor** John Davies **Nursing Notes** Denis Cobell **Office Manager** Margaret Flanders.
Acknowledgement Dean Flanders.

The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

Volume 110 Number 2457 June 1996
ISSN 0017–5870

Guy's Gazette, Boland House, Guy's Hospital, London SE1 9RT. Tel (0171) 955 5000 ext 5413. All rights reserved.

Printed by Hobbs the Printers Ltd, Brunel Road, Totton, Hampshire SO40 3YS

Passim

Thomas Guy must be spinning in his grave. In recent years the flow of staff and patients entering the hospital has moved from the front quadrangle and the colonnade to Great Maze Pond. Many now come from the approach to London Bridge Station, cross the bridge over St Thomas Street and descend the steps to the road below. The sight which greets them almost resembles the images of Bosnia with which we have become so familiar.

Many have found it hard to reconcile the presence of McDonalds with the elegant east wing of Guy's House. It is almost bearable because the front is discreet and unrecognisable. The rear aspect is another matter and in the morning the appearance is disgusting. To say it resembles a pig-sty would be unfair to pigs; it is a noisome and unpleasant garbage dump which should be removed.

It would be interesting to know if anyone from the Facilities Directorate uses this entrance to the hospital early in the morning and sees not only McDonald's mess but the general dilapidation which greets visitors to Guy's who arrive by this route. What a disastrous first impression it must be.

Thomas Guy's original hospital building now contains no patients. It is full of managers. Surely there is one who ought to walk regularly around the site identifying the areas, and there are many of them, in urgent need of cleaning and maintenance. This is nothing to do with the proposed changes of use of the buildings within the trust. It is a matter of good housekeeping and pride in the appearance of our hospital. The present state of what has become the main entrance is intolerable. Many other areas are badly in need of attention. A programme of improvement is long overdue.

Letters

We would like to hear your views on any issues raised in any of the Gazettes, or anything to do with Guy's. You may have an opinion you would like to share with the rest of the readership. We would like to see some of your points published in future issues. If you feel you want to air your thoughts, please write to the editor.

You are reminded that it is the editor's discretion whether to publish a letter and that derogatory personal references to any individual will not be acceptable. We will, however, do our best to let you have a say.

NB: Copy date for Gazette is 20th of each month

Guy's, London?

Dear Sir,

I read Robert Walton's letter with sadness. We *are* becoming a secondary institution - how very sad.

I noticed today in the Daily Telegraph some very apt comments by Philip Deverall concerning who should be allowed in an operating theatre. The thing that grated most (apart from the Princess of Wales) was that he was described as Head of Cardiothoracic Surgery at Guy's Hospital, *London*. Then, this afternoon on the afternoon news, we were told that a patient had been taken to Guy's Hospital in London.

Not so long ago, we would have merely been informed - 'he was at Guy's' - or 'The patient was taken to Guy's'. Everyone knew Thomas Guy's Hospital was in London and that to be a Guy's man or woman was an immense privilege and a source of great pride.

As I verge on my 8th decade, I can only hope this pedestrian and proletarian trend can be reversed - Tommies is not a bad outfit - but we all feel Guy's comes out top - and by a long way.

Yours faithfully,

MJ Fawcett

Dental Ball defence

Dear Sir,

I write in reply to a letter published in the January issue of the Guy's Hospital Gazette where Mr Michael Dods expressed his disapproval of events at this year's Dental Society Ball.

The predicament the Dental Society was in needs to be explained. Since the change in the structure of the dental course with final years qualifying in June and going on elective between Christmas and Easter, the ball had to be re-scheduled from February to November so that they could attend. The Grosvenor could not accommodate us due to pre-booking so the Hilton was chosen to be the venue. Admittedly, it was not ideal but given the circumstances, I feel that the Ball Secretaries, Dominique O'Leary, Helen Davison and Almas Hussain did a fantastic job and I congratulate them on organising a most enjoyable evening.

As for the behaviour, it disappoints me that the older generation sometimes find the younger's high spirited celebration offensive. Maybe more frequent social gatherings (Guy's Bar?) where both attend, could bridge a social gap. In the meantime, I look forward to meeting Mr Dods at the Hilton next year.

Yours faithfully,

Samy Darwish

Precision Surgery

Mr Bill Heald, who trained at Guy's and is now the vice-president of the Royal College of Surgeons, has recently had his 'total mesorectal excision' technique for colorectal cancer been approved by the RCS.

The pioneering technique, which he had been demonstrating throughout the world for the past 17 years, is a more specific and precise procedure that minimises removal of healthy tissue and often avoids the need for colostomy bags. Projected figures suggest that 2,500 lives a year could be saved. The guidelines for the new technique are now being assessed by the Department of Health and will then pass on for approval by the NHS executive.

New Clinical Dean

Professor Gwyn Williams is to take over as Clinical Dean for UMDS on August 1st from Professor Phillips. As a result, he will resign as Chairman of the Medical and Dental Advisory Committee at the end of July to be replaced by Dr Richard Thompson.

Marathon Successes

Congratulations to all those who took part in the 1996 Flora London Marathon.

Many students and staff ran to raise funds for various charities and departments at Guy's. As far as we know, the fastest time was by 4th year medical student Jeremy Carter who completed the course in 3 hrs 10 mins.

NEW SUBSCRIBER
BANKERS ORDER SUBSCRIPTION FORM

Photocopies are acceptable

Please return completed form to:

Guy's Gazette

Boland House
Guy's Hospital
St Thomas' Street
London SE1 9RT
Tel 0171 955 5000 ext 5413/5414

To the Manager

_____ Bank plc

_____ Branch

_____ Address

_____

Please pay the sum of £15.00 annually on _____
commencing 19____ to the credit of:

Guy's Hospital Gazette
Account No. 80401269
Midland Bank plc
Southwark Branch
28 Borough High Street
London SE1 1YB

and debit my account accordingly:

Name (please print) _____

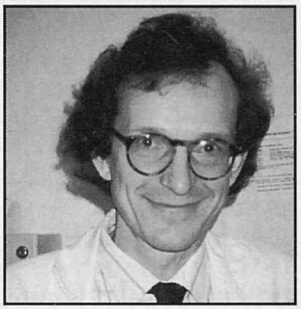
Account No. _____

Address _____

_____

Signature _____ **Date**_____

Interview with Dr Andrew Warren



March 6th 1996, Johns Hopkins Hospital, Baltimore, USA

Dr Andrew Warren is an Attending Psychiatrist in the Department of Psychiatry at the Johns Hopkins Hospital in Baltimore, USA. He has been working there for 15 years, having previously graduated from Guy's. In view of the fact that more and more students are now considering overseas employment, I took the opportunity to find out more about the former Guy's man who decided to leave the flock.

Can you please tell us a little bit about your background, your medical education and postgraduate jobs etc.?

I did my undergraduate training at Oxford for six years, from 1971-1976, before going to Guy's to do my clinical training. I did a Ph.D. whilst I was at Oxford and I'm glad I did it that way round because I think it would be quite difficult to go back to straight research from clinical work. Guy's, I thought was particularly helpful because of the volume of patients one saw and the number of clinical examinations that one did. I think that the clinical training there stood me in good stead for coming to America because of the emphasis on clinical skills and seeing clinical signs and being responsible for patients. I think that the English medical graduates see a lot of patients and have good clinical skills. After graduating at Guy's I did both of my House jobs at Brighton, six months of Medicine and six months of Surgery. This was pretty terrifying to start of with because it was such a change from a sheltered environment of being a student, to having to make decisions and be responsible for those decisions. I think one thing I wished I'd done more as a student was to get involved more in the therapeutics of how patients were being treated, I'd liked to have been more aware of how to do things before being plunged into the deep end of having to do that as a House Officer. However,

the pre-registration period was very enjoyable and a great experience. The next posting I had was at the Hopkins and was part of a Psychiatry residency programme.

When did you first develop an affection for the Johns Hopkins?

Whilst I was at Guy's, I spent my elective period at the Hopkins to follow my interest in Psychiatry which had developed during my undergraduate years. I wanted to use this time to see if Psychiatry was as interesting as I hoped it to be and I was also very keen on knowing whether there was actually a biological basis to Psychiatry. I'd been very put off by the psycho-dynamic basis of Psychiatry that I had seen so far and because my background was in genetic research and I'd been so impressed that there were fixed genetically determined programmes by which organisms develop and how metabolism is regulated and because the brain is such a highly specialised structure that I thought that there must surely be biological programmes underlying how the brain works and develops. Psychiatry was a very emerging field that could be looked at in this light. By studying behaviour I could try and find out more about these biological programmes. I wanted to come to a place which had this biological basis and I'd heard that Johns Hopkins had this approach to Psychiatry, so I went over for six weeks to find out if this was true and I was pleased to say that it was. The Hopkins approach to Psychiatry is quite biologically based and underplays psychodynamic or psychoanalytic interpretations. I had a wonderful time there and wanted to go back and do more. I think that the thing that impressed me most was the enthusiasm that people had for the subject, it didn't matter who you were but if you had an idea people were enthusiastic about the idea for its one worth, it didn't matter if you were a student if the idea was a good one people were keen on following it up. Also the facilities at the Hopkins were so impressive both for being able to investigate the patients with MRI scans, for example, or by blood tests. There was a huge degree of clinical expertise there because it is such a large place. There is such a diversity of interests that no matter which technique or subject you wanted to use or were interested in, there was always somebody at the Hopkins who was an expert in it or had a specific interest in it, that was ready to talk to you about it. I was so impressed that I knew immediately I wanted to go there to work.

Did you have any regrets about leaving England?

Yes, I had lots of regrets about leaving England, I felt guilty because England had trained me and I had not had the chance to return the service but I hoped that

my contributions in research and so forth would be reward enough. Whether that is true or not I'm not quite sure but I hope that that will prove to be the case.

Going back to your days at Guy's, are there any things that you remember with great fondness?

I remember with affection the Consultants whose firms I was on, in particular Dr Scott and Dr Joiner, who were great characters who filled us with inspiration. I don't think that it was their stature or prestige that I respected but more so their excellent clinical skills with which they could expertly evaluate a patient. I don't think that there was so much a stereotyped great Guy's man, but a stereotyped great hospital. In fact the greatness probably came from the high quality of the junior staff who were involved with the day to day teaching and patient care. Everyday we would meet with the Senior Registrar or Registrar who would stand by you as you examined a patient and guided you accordingly. I don't think this is done as well anywhere else, as it is at Guy's.

So how did you proceed from the confines of the NHS to working in the USA?

I think the system has probably changed since my time, I've been at the Hopkins now for 15 years, but I had to take a series of further examinations just to become a qualified practitioner in America, these were called the VISA qualifying exams. They were pretty difficult exams which required a lot of revision which was particularly difficult because of work. The fact of the matter was that there was no real transitory period, one week I was doing House jobs, the next I was starting my residency in the USA.

What are the key differences in medicine between England and the USA?

There are differences in every aspect of medicine; the drugs are different, the work-up of the patients is very different and the procedures are different. I was very glad that I was exposed to both. I think good American medicine is very good, people are very thorough, they will evaluate all possibilities rather than just go by clinical signs. I think this is very valuable. The other valuable thing about American medicine is that there are lawyers who make clinicians think very carefully about the consequences of their decisions. Unfortunately, the litigation

system goes to extremes in the USA. However, the thought that your decisions may be reviewed is healthy.

Was it difficult to adapt to these differences?

The transition was quite difficult for several reasons but the actual adapting to medicine in America was not that difficult as I was in a training programme which was well organised and structured with close supervision by an Attending Physician. It proved to be a major trauma to move to a new country even though we perceive America to be culturally similar to England. However, the whole outlook to life in the States is completely different and it took six months to a year before I started to feel comfortable with aspects of life outside the hospital. The aspect of not having a National Health Service was quite concerning to me, the notion that certain people may be excluded from receiving healthcare was morally disturbing for me. However, this common belief is not exactly true, even if somebody doesn't have insurance, if they come to the ER at Hopkins they will receive care. There is much free care given at Hopkins, nobody is refused care because they don't have insurance. However, the converse is also true; how much insurance one has determines how much care one receives. It is very disheartening to be told by an insurance company reviewer that you can not give certain treatment to a patient or you may not perform certain investigations or that they can only stay in hospital for a certain length of time, that I think is a tragedy. I think this a very sad thing to happen to medicine and I think its sad that it seems to be happening to medicine in England.

What are the advantages of studying or pursuing a career in medicine in the States as opposed to in England?

There are advantages in both systems. The advantages, I feel, in England which I'm pleased to say are also apparent at the Hopkins but perhaps not as much elsewhere, as far as the teaching is concerned, are to do with the greater emphasis on small group teaching i.e. 'the firm'. This is very valuable because it increases student involvement in patient care and also brings about a sense of belonging to a team. Certainly in the Psychiatry department, this theme of a team effort is kept going, with the student taking an integral role alongside the resident, Attending, nurses and ancillary staff. This all goes toward making a good product, just like making a Volvo! Another advantage with the American system is that there is a fixed programme for postgraduate education. For example, if you enter a residency programme for three years, you know exactly what you will be doing, where

and when in time, whereas in England you just don't have these assurances and this results in added pressures in constantly having to make arrangements for the next job. The disadvantage, however, of the residency programme is the narrowness that that might impose. One regret that I have was not doing enough post-graduate medicine work, as this undoubtedly would have equipped me with better skills to deal with complicated patients, such as those with AIDS.

What things would you advise in particular to those people thinking of working in the USA?

I think it's important to emphasise that moving to another continent is a major change and I would say to those who may wish to pursue a career in medicine abroad, where ever that may be, to go and find out what its like and whether they can see themselves living in a totally new environment. The elective period would probably be the most ideal time to do this. Bare in mind also, that moving away will also mean giving up what you have at home i.e. friends and family. You should establish what it is you want from working abroad that you can not achieve where you are and whether after balancing things up that it is still worthwhile.

What were the big incentives for going to the USA for you?

I think traditionally the big incentive has been thought to be the greater financial reward. However, I feel that this is something that has been overstated, for example my salary currently is probably comparable to what I would be earning in England. Perhaps in another clinical situation I could be earning more but the choice of profession should not necessarily be biased on financial merits and I don't think that should be the reason for working state-side. I agree that one could be financially more endowed working in private practice in the USA, but the opportunities for doing so are becoming fewer and fewer now that managed care is becoming more common pace in America.

The main incentive for me was the possibility of being able to combine research with clinical work. It would have been almost impossible to do good research as well as good clinical work in England, something that I have found possible to do at the Hopkins. However, the opportunities for doing this in modern times is also becoming less and less, with research grants becoming harder and harder to obtain. The other thing was the American lifestyle which although having its downside i.e., the violence aspect, all in all has a lot to offer, particularly in the Arts.

So, what are your research interests and how do you split your time?

How I would like to split my time would be fifty percent research and fifty percent clinical care, however this does not work out as half-a-day in the lab and half-a-day on the wards. I have to be responsible for patients full-time for certain parts of the year. For example for two months I may be entirely devoted to clinical care and after this period I may be able to spend another two or three months entirely in the lab. Hopkins encourages the 'rule of thirds' that is a third of the time doing clinical work, another third doing research and the last third teaching. That's the goal but I think most people tend to emphasise one or the other.

As far as my research is concerned, this has changed over the years. I started of working almost purely on basic genetic research, especially in Down Syndrome. I was involved in making the first detailed map of Chromosome 21 and studies on the genetic basis of the non-disjunction that occurs. One of my current projects involves following a large cohort of Down Syndrome patients, longitudinally to look at the early symptoms of Alzheimer's Disease and correlate these with the first neuropathological changes seen on MRI.

Would you ever consider returning to England to work?

I would love to go back to England. The question really is whether there are any opportunities for doing excellent research and excellent clinical work. I am not fully convinced of that - medicine in England seems to be going through a great period of transition, and I am not fully convinced that England can offer the same opportunities for excellence as the Hopkins. However, I would like to return, after all England is home.

How much of the changes regarding the future of Guy's are you aware of and what concerns do you harbour?

I feel that there is a lot of identity that I and other former Guy's graduates have with Guy's and I think that we are all concerned about Guy's ceasing to be an independent unit; I think this is a great shame. I feel very warmly about Guy's and if the spirit of the hospital disappears then that will be a great loss to English medicine. The perception we have is that American medicine is shifting towards how English medicine was and that English medicine seems to be heading towards the American system of managed care and insurance. I think this is bad because all it seems to be doing is underlining the economics of health care and putting

that at a premium. Although it may save money now, it is likely to have devastating effects in the long term. It is very demoralising to be dictated to by insurance companies and health management organisations in matters of health, something you are expert in but something which is only interpreted with numbers by a company accountant.

How much contact do you have with other alumni?

The answer to that is very little. It is difficult to maintain contact because I am so far away and there are not opportunities to do so. The idea of visiting fellowships has provided such an opportunity in the past and that has been great but these have been few in number and time. There are a number of old Guy's people here at the Hopkins, and I am very friendly with them but I would like to have more contact with others.

Finally, how do you like to think of yourself, a Hopkins research Boff, or still a Guy's man?

To me the two are not different! For me one is just an extension of the other. I could not be one without the other and I have an equal sense of allegiance to both.

RT

Now available, in limited stock, full colour prints depicting Thomas Guy discussing the plans for his hospital with Dr Mead, the physician, and Mr Stear, the architect who designed the East Wing.

The cards are available blank or with Christmas Greetings.

Price: 10 for £6.00 + £1.00 p & pkg
Size: 218 × 163 mm

When ordering, please indicate choice of message

Cheques may be made payable to Guy's Hospital Gazette

Reflections And Hopes For General Practice

A Retired GP's Perspective

Being one of the early retirers from general practice it came as no surprise to hear that recruitment of Family Doctors is, as *the commentator* stated, at crisis levels. I was not a bit astounded, as it seemed to think I should be, to hear of the haemorrhage of doctors from the National Health service, particularly family doctors, new entrants to general practice switching careers and the old guard leaving just as early as the finances would allow.

I know from the experience of my doctor daughter that the vocational training schemes for general practice are currently under-subscribed, since she was offered the choice of several placements. Ten years ago our local scheme had 140 good applicants for 7 places which, this year, they are struggling to fill. It is clear that the future of the family doctor service is uncertain.

'It is clear that the future of the family doctor service is uncertain.'

Three years after retiring hurt, listening to the radio is still a new found treat and looking out at the snow covered hills of Sutherland as I tie flies is another, particularly in February. It was an understood and closely observed custom in the old style general practice that the taking of holidays between the end of September and the beginning of April was to be avoided. This certainly eased the pressure on the partners during the seasonal epidemics. I also remember a certain sense of duty (what an old fashioned word) to be available for the patients during these times and also a sense of consideration for one's partners and their families. The senior partner was, in my early years, simply senior and the junior partners were afforded privileges according to the pecking order. This hierarchical structure has now largely disappeared yet it did have some worthwhile aspects. After reaching a certain age, it was

customary for the senior partner to be excused night duty and even weekends, making life more tolerable and retirement less of a shock. Juniors anxiously awaited their Nirvana. Egalitarianism now rules and in my latter years of practice it was sad to see how aggressively holidays and time off were acquired, demanded even. This, I suppose, was due to the pressures under which we had already started to buckle, but I think the present dissatisfaction among family doctors and the rock-bottom morale causing this hiccup in recruitment has other significant causes than just the 1990 'Contract' and the spiralling work load subsequently dumped on to them.

When I first walked through the gates of Guy's Hospital for my interview in the fifties, the East Wing was still in ruins from one of Hitler's bombs. Not so the rest of the hospital, which ran like clockwork; no managers in those days, just a daily meeting between the medical superintendent, the Matron, hospital secretary and the Deans of the Medical and Dental Schools. I was fortunate to enter our noble profession and one of which I am still inordinately proud. I left the family of that hospital older, much wiser and impatient to start my chosen speciality of general practice. There were no vocational training schemes then and I commenced my first job as junior partner on the Monday morning after spending my final weekend on call as Obstetric House Officer. No sleep, no training and little experience. A fountain pen, a stethoscope, a bag full of obstetric instruments and a debt equal now to £40k. Upstairs, my wife decorated, looked after the baby, answered the phone for repeat prescriptions, visits and queries and when time allowed would come into the surgery to keep alight the waiting room fire. The work load was heavy. Often thirty, occasionally fifty patients were seen in one non-appointment surgery daily and the visit rate could spiral to thirty every day during influenza and measles. One night off every three weeks was the order of the day plus one half day, back on duty at midnight. One's work was literally one's life. The job satisfaction was immense and although the hours worked and the responsibility undertaken was huge, the workload was clinical. It was what I

'The job satisfaction was immense and although the hours worked and the responsibility undertaken was huge, the workload was clinical. It was what I expected and trained for.'

expected and trained for. Treating sick people who trust and respect one is not hard work.

How different now. Clinical and pastoral work has been squeezed out to make way for the unproven worth of the 1990 contractual impositions. The doctors are worn out, have an increasing sense of low esteem made worse by a government who have encouraged the patients to complain and now have even tried to induce complaints from doctors about their colleagues. A classic case of divide and rule.

I was fortunate in never having had a complaint during 30 years of service so it is particularly sad to read of young doctors who have committed suicide due to the stress of complaints hanging over them. Complaints for negligence are not new and although the old jibe that doctors bury their mistakes may have had some veracity, it is no longer the case. Accountability is not something the medical profession shies away from, but career-destroying complaints from events of a trivial and often nonsensical nature are well on the way to ending the doctor - patient relationship as it used to be.

'Hospital consultants' perception of general practice and family doctors influenced a generation of medical students with 'hilarious' accounts of inaccurate diagnoses and inappropriate referrals.'

There were no recruitment problems in the new post war NHS; indeed, there were often 50 applicants for practice vacancies in areas which offered little in the way of financial reward or gracious living. Becoming a family doctor in those days was often a safety net for those who had been prevented, often as a result of interrupted training due to war service, to continue their chosen speciality. There were also those individuals who 'ended up' as family doctors after slipping from the training ladder; students setting out early in their careers to be family doctors were probably in the minority. The fifties and sixties saw another drop in the number of applicants for general practice (as it was now being described, some avante garde individuals even having the nerve to hint that it was a speciality).

Hospital consultants' perception of general practice and family doctors (those of whom did not send them private patients) influenced a generation of medical students with 'hilarious' accounts of inaccurate diagnoses and inappropriate referrals. The old chestnut from a casualty referral letter 'please see and treat, ?pain in ?abdomen' was sadly not apocryphal; nor was the scenario of the tired, bored doctor, sitting in his lock-up shop front surgery in the Whitechapel Road wearing his tweed overcoat and trilby hat, smoking a cigarette, writing out prescriptions, barely looking up from his desk.

It is hardly surprising that the intake to practices fell to an all time low until the late sixties and from then, for the next thirty years, family doctoring became attractive, respectable and specialised. Endowed with its own Royal College and post graduate membership examinations, training improved and with the institution of mandatory post graduate experience the patients, I believe, had the best service they have ever received.

When did it all start to go wrong? During those salad days of the seventies and eighties the popularity of medicine as a career was never higher and the medical schools became overloaded with applications, not only from the traditional stereotype (ex-public school, rugby-playing sons of alumni) but from an ever increasing number of individuals from across the social classes, some mature, many from overseas, most of whom had impeccable qualifications. How did the over-subscribed medical schools select suitable candidates? Clearly, some applicants shone, some were never going to make it but most were of suitable standard. One tangible quality for assessment was academic achievement. Some medical schools simply selected those individuals who were going to reach 3/4 grade A's standard. Some even selected on this basis alone without interview. Few, if any, biased their selection because of outstanding sporting or other abilities as in days of yore (one famous London hospital had no less than 13 Springbok international rugby players in their 1st XV before the last war).

The cynics predicted that we would have a generation of 'spots 'n' specs and blue stocking' doctors. Certainly, the whimsical characters featured less and the cerebral, serious minded, more. Was that a bad thing? As things turned out it probably was not, certainly from the government's point of view. There was another profoundly important factor which influenced the selection of applicants - sex. With political correctitude, the intake accelerated to a 50/50 male/female ratio and of the whole, at least 50% were foreign nationals. Nobody can argue against the perfect fairness of this but it had important consequences in future

medical manpower in the United Kingdom which were not fully appreciated at that time.

The perception that doctors worked full time was soon to be challenged by the women graduates. Traditionally, lady doctors undertook part-tine work during, for example, later pregnancy and for a variable period of time following their confinement, thereafter returning to full-time work. Quite reasonably, and not before time, some of the new entrants into practice requested the period of part-time work, but wished to continue as part-timers so that they could raise their families. Some opted for a retainer scheme and took, as a result, a sabbatical which could last for 5 or more years, after which most, but certainly not all, returned to practice after a short period of retaining. After qualifying, the majority of foreign graduates were anxious to acquire our prestigious UK post graduate qualifications. In order to satisfy the regulations their work naturally restricted them to the hospital service; very few entered general practice and most returned home to take up senior positions, never to work in, or return to this country.

'The GP became the final resting place of all the bucks put up by any social service query, school illness certificate, shot gun licences, passports, freedom from infection and a thousand other requests.'

The Royal College of General Practitioners really began to grow teeth during the seventies and eighties. With the blossoming respectability came the creation of departments of general practice, professors, lectures and the advent of mandatory training for aspiring graduates. The cloak of academia hung awkwardly on many practical individuals, but there was no shortage of those who could see the opportunity to change the face of family doctoring, and make a name for themselves in so doing. Not unreasonably, some of those at the leading edge of general practice development wanted to have respect not only from the patients but from other members of the profession. Some slavishly followed the works of Michael Balint and others, becoming devotees of the principle that the psyche was the root cause of somatic complaints. A course, in my view, to be compared with walking blindfold through a minefield. They certainly became specialists since few, if any, understood what they are talking about.

During this time, general unemployment was increasing, particularly for graduates with once respectable degrees. It certainly did not pass unnoticed to some

individuals who could see that a medical degree would still offer lifetime employment and an instant access to the middle classes to boot.

What happened, I believe, in those years had a profound effect upon the public's perception and subsequent attitudes to their own doctor in particular and the medical profession in general.

My memory of 'our doctor' during the advent of the National Health Service, was of a kindly man, dressed in a suit, shiny shoes, properly spoken, possibly a bit 'posh'; a man to be respected and of whom everybody spoke well and a man with a motor car (this I remember probably more than anything). Forty years later the academics had changed the image. The new men and their clones had replaced the suit with a Fair Isle sweater and the shiny shoes with sandals. The women 'power dressed', wore large earrings and swore.

Bear with this painful stereotype a mite longer. The casual look had become accompanied by a matching 'easy approach' to the patients. Christian names replaced the more formal salutations of doctors, patients and the doctor's staff. I have never found this comfortable and still recoil when I hear nurses addressing patients, particularly the elderly, by their Christian names, but not quite as much as when they are described as 'clients'.

My contention is that we did not help ourselves during this period. The image became unworthy of the dedication, training and responsibility of the profession and I think, in spite of the improved medical services, the patients began to lose respect and consideration. This was made worse by the increased use of the genetic term 'Gee Pee'.

The GP became the final resting place of all the bucks put up by any social service query, school illness certificate, shot gun licences, passports, freedom from infection and a thousand other requests. How often does a report end with those words '...but if you are not entirely satisfied see your GP'.

It was during the latter part of the eighties that I began to realise that there had been a change in the ethos which had guided me in my early years. Important looking men carrying black brief cases embossed with gold initials started to visit the practice and at first gently hinted (quite reasonably) that we should not be using so many expensive drugs for our patients when a cheaper alternative would suffice. Later, this was reinforced by the intimation that part of our income would be withheld if we persisted in giving our patients the medications we thought were best. This, now I am free from the fetters, I can accurately describe as blackmail.

I often used to think of some 'off the cuff' advice given by one of my old teachers at Guy's.... 'Treat the dockers as you would Lord Nuffield... In fact, treat everyone as though they were Queen Victoria'. I think the original epigram had not travelled well, but I knew exactly what he meant. Rationing of care had arrived and She would certainly not have been amused by the methods of its provision. The patients had become, as I once overheard (to my abject disgust), from the lips of a once respected family doctor 'vehicles for generating income for the practice'.

Now the status and security of the family doctor is further debased by the patients' charter and the carte blanche it provides for 'GP bashing'. During the last five years there has been a five fold increase in night visit requests. The cause for this and the increase in daytime visits is multifactorial, but the patients' charter alluded to above did nothing to curb this trend. With the 30% increase of paper work and the experience of negative equity problems with practice premises, and little or no increase in real income during the same period, the reason for the recruitment crisis becomes clearer. Is the answer to pay the doctors more? No. It is only a part of the solution. The real answer is to restore for them the kind of respect and feel-good factor which I was fortunate enough to experience during my career. This can only come from a robust support of the family doctor service from government; a doctors' charter perhaps, providing doctors with protection against abuse, physical and mental; guaranteeing adequate time for sleep, rest, recuperation and quality time at home with their families. In addition there must be incentives for improving clinical skills, reduction to a minimum of the paperwork nightmare and sequestration of the growing numbers of effete management who continually interfere in the smooth running of doctors' practices.

'If the spiralling demand from patients continues unbridled, in spite of government campaigns, it may be necessary to off load more of the routine clinical work to suitably trained paramedical staff.'

If the spiralling demand from patients continues unbridled, in spite of government campaigns, it may be necessary to off load more of the routine

clinical work to suitably trained paramedical staff. Certainly in the emergency situation this has proven successful and safe. We will, however, need to train more doctors and the emphasis of that training in the postgraduate years should be on clinical and psychological medicine. A well trained family doctor with a sound clinical background will be a more efficient doctor for his patients than an individual who concentrates his or her time and efforts on meetings and pursuance of income generation. The competent clinician will appease any government by cost cutting by reduced specialist referral and by the more appropriate prescription of drugs and moderated use of expensive investigations. This is far more important than the current vogue for acquisition of business skills (some family doctors are even studying for the MBA while running their practices). Medical practice is not primarily a business, although we are now lead to believe it is. Business skills should be acquired and deployed by the practice managers and the secretaries.

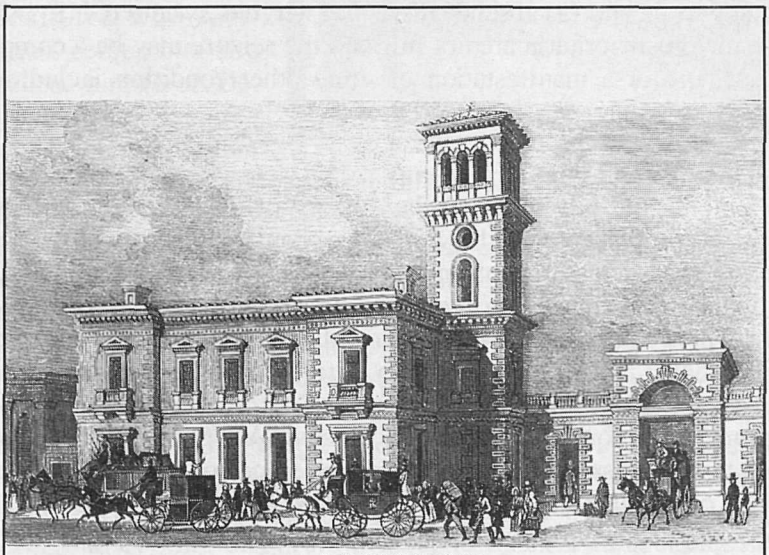
Increasing the amount of time available for the doctors to treat their the patients must be the paramount concern and aim of the practice managers, since the reputation of the practice and of the doctors will ultimately rest on the clinical and pastoral aspects of their work, not on how much income they can squeeze from the system or what sort of cars they drive. The constant rush and stress of modern practice can lead to mistakes and these, we have seen, can be devastating for both patient and doctor. Stress is killing off doctors and leading to the early retirement of an increasing number each year, and if action is not taken, the family doctor service we have grown to accept will end. There will, of course, be a service of sorts, but the private sector will feature large and the patients will then understand what a two-tier system really means.

The needs of our patients are simple. Firstly they need to feel that 'their doctor' cares about them and knows about them. They need to feel secure in his or her abilities and they need to know that they can get an appropriately urgent appointment to see their own doctor and, if necessary, to be seen at home during normal and unsociable hours. It has been the difficulty in providing these latter needs which has caused most of the angst in the profession's relationships with patients and the government. Because of the time which has been unprofitably wasted trying to implement the reforms, it has been extremely difficult for family doctors and their staff to cope with the visit requests and appointments. 'You have to know you're going to be ill 3

weeks in advance' the patients say. It is a reasonable, indefensible point which causes a lot of bad feeling throughout a practice.

Currently there is a communal lack of respect and trust between our profession, the patients and government, but it is important to understand that the blame is not clearly weighted. There has to be a new style of dialogue since current discussions seem to be confrontational and inharmonious, inevitably ending in deadlock and further demoralisation. The solution will not be found by cash payments or providing a '9-5' job structure but by giving the doctors the chance to look after their patients properly and have a family life like other professionals. They will keep alive the NHS for any political party provided their voice is heeded and the advice from bodies of doctors, rather than politically selected individuals, is accepted. The overall winners will be the patients and the profession will, I hope, once again attract young people of the right quality and outlook in sufficient numbers.

David Rhodes



London Bridge Railway Station.

The Guy's Hospital Staff Round: Case Reports

A little more than a febrile convulsion

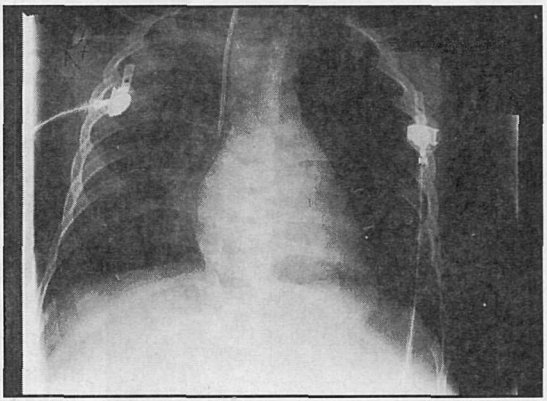
Febrile convulsions occur in between 4 and 5% of all children, and are commonly associated with illnesses that cause high fever late in infancy such as otitis media. Simple febrile convulsions are a form of tonic-clonic seizures meeting the following diagnostic criteria: (1) occurrence between 6 months and 5 years, (2) fever at the time of attack, (3) brief duration, usually less than 15 minutes, (4) absence of neurological abnormalities in the interictal period, and (5) absence of central nervous system (CNS) infection. If these diagnostic criteria are not fulfilled the seizure may be a complicated febrile seizure or a manifestation of some other condition including CNS infection.

Case history and clinical findings

A 14 month old boy with a 2 day history of poor feeding, lethargy and associated fever presented with a generalised convulsion lasting for 30 minutes with more pronounced fitting on the left side. He was seen by the General Practitioner and treated with rectal diazepam prior to transfer to the local hospital where a diagnosis of febrile convulsion was made. Review of his past history revealed that he had been born at full term by a spontaneous vaginal delivery being the second child of unrelated Afro-caribbean parents. He was developmentally normal and fully vaccinated. At 10 months of age he was referred to a neurosurgeon because of the presence of a small bony defect in the right occipital bone. A skull xray was unremarkable and the defect subsequently closed spontaneously.

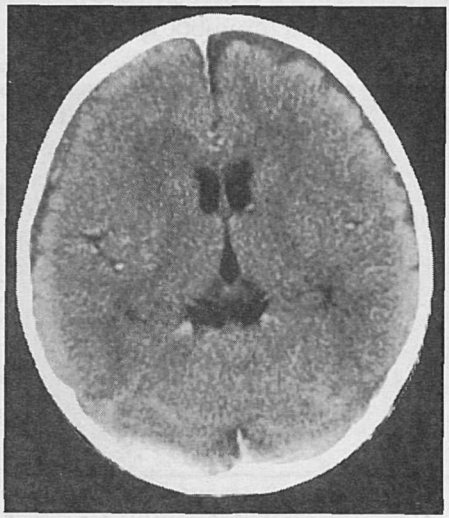
Six weeks prior to the current illness he had had a simple febrile convulsion following chicken pox, from which he had recovered with no sequelae.

On admission to the local hospital his condition initially improved with symptomatic treatment for the fever and there was no focal neurology. His condition deteriorated 36 hours later when he became tachycardic, hypotensive and poorly perfused. There was a decrease in his level of consciousness associated with decreasing respiratory effort, an arterial blood gas showed a mixed metabolic and respiratory acidosis; pH 7.18, Pa CO_2 8.0, Pa O_2 13.0, Base excess -8.0, HCO_3 23.0. A blood count showed thrombocytopenia and leucopenia. There was some shadowing in the right upper zones on chest x-ray. The circulatory failure was treated with volume resuscitation (30 ml/kg of 4.5% human albumin solution) and inotropic support in the form of dobutamine (5 mcg/kg/minute). Blood cultures were performed and cefotaxime and gentamicin administered. Despite supplemental inspired oxygen the respiratory failure progressed necessitating endotracheal intubation and ventilation. He was referred to Guy's for intensive care management.



On arrival at the local hospital the paediatric retrieval team paralysed (infusion of vecuronium) and sedated the child in order to achieve adequate mechanical ventilation, administered a further 40 ml/kg of 4.5% albumin, established arterial and central venous access. The addition of a dopamine infusion initially at 5 and subsequently at 10 mcg/kg/minute was necessary in order to stabilise the child prior to transfer back to Guy's Paediatric Intensive Care Unit. On arrival at Guy's repeat blood count showed a Hb 8.3 g/dl, WBC 1.6 x 10^9/L and platelets 62 x 10^9/L, clotting and biochemistry were normal, sickle screen negative and the chest x-ray showed extensive shadowing. (Figure 1.). Our working diagnosis was septic shock with acute respiratory failure secondary to either a septicaemia or meningitis. In view of the initial chest x-ray being abnormal pneumococcal pneumonia seemed the most likely primary diagnosis.

Over the subsequent 8 hours there was a steady decrease in the ventilatory requirements with a fall in the Fi O_2 from 0.80 to 0.35 and fall in the pressures from 30/4 to 23/4. At this time the right pupil became dilated and unreactive, the anterior fontanelle was full but not tense, the optic fundi appeared normal and there was a conjugate gaze. Intravenous mannitol was given as treatment for possible raised intracranial pressure. The infusion of vecuronium was discontinued in order to observe any focal neurology, the child was not fitting but there was a paucity of movements. The antimicrobial therapy was broadened to cefotaxime, erythromycin and acyclovir to cover the treatable causes of encephalitis. A computerised axial tomography scan of the head was performed (Figure 2). This demonstrated a decrease in the fluid over the right cerebral hemisphere and blunting of the sulci, there was no clear mass effect , intracerebral bleed or space occupying lesion. No intervention was taken and a repeat CAT scan in 24 hours was planned. Blood cultures taken at the local hospital confirmed the diagnosis of Streptococcal pneumonia, with a normal pattern of sensitivity.



During the subsequent 24 hours there was a steady improvement. The inotropes were weaned and the ventilatory requirements decreased. the total white cell count increased to 6.8 x 10^9/L and the thrombocytopenia persisted (45 x 10^9/L) The right pupil was still enlarged but had a sluggish reaction to light, and a grimace to deep pain was elicited. A repeat CAT scan of the head showed a right sided subdural collection (Figure 3.)An EEG showed high amplitude generalised slowing but no clear focal, paroxysmal or lateralising features.

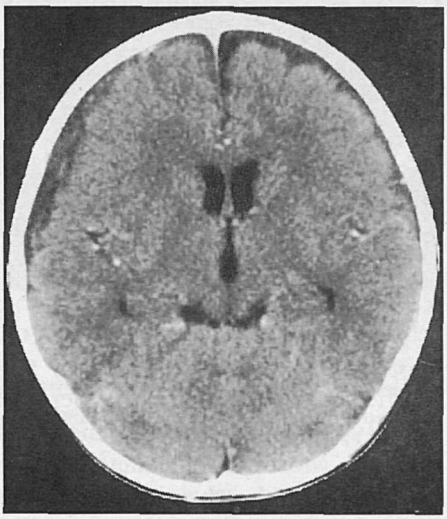
On Day 5 the child developed seizures in the form of eye deviation to the right with lip smacking and occasional twitching movements of the limbs. These were well controlled with regular Phenytoin. At this time his occipito-

frontal circumference (OFC) was 49 cm, which was unchanged from the measurements taken at admission.

As the platelet count had risen to 164 x 10^9/L, a subdural tap was performed, yielding 0.5 ml of sterile xanthochromic fluid with 600 WBC/mcl and the presence of numerous atypical lymphocytes was noted.

The following day a repeat tap was performed under ultrasonic guidance. Because of the suspicion of underlying malignancy this was sent for cytological analysis, which showed only mixed acute and chronic inflammatory cells.

On Day 7 the child was extubated. He now had a complete 3rd nerve palsy, with pupillary dilatation, a 'down and out' appearance and ptosis. He remained akinetic, hypotonic and areflexic, and would moan when touched. There were no further fits.



He was transferred to the ward on Day 9.

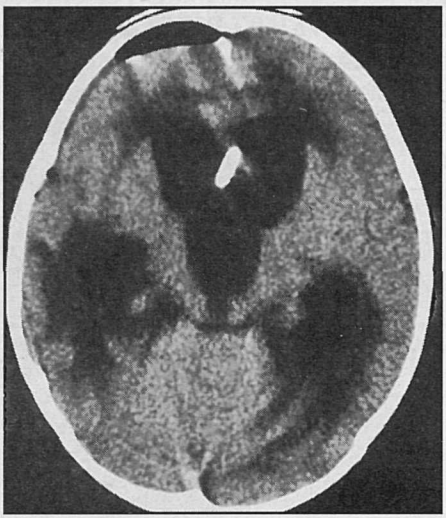
By Day 14 there had been some neurological improvement. He now had a conjugate gaze, was fixing on objects but not following and had a persisting ptosis. Occasional spontaneous movements were noted in the upper limbs only.

However bladder dysfunction had developed necessitating catheterisation, his OFC had increased by 0.5 cm and he was also febrile. Because of these new findings a Magnetic Resonance Imaging scan of the head and spine was performed which showed gross hydrocephalus, a large right sided subdural collection and a posterior radiculopathy.

He was transferred to King's College Hospital and underwent emergency decompression via an external ventricular drain along with drainage of the subdural effusion (Figure 4). Four days later (Day 21) a ventriculo-peritoneal shunt was inserted.

By Day 23 he was more alert, had a convergent gaze, was fixing and following and could adduct his right eye past the midline. Upper limb move-

ments continued to improve, but with slightly increased tone and brisk reflexes. The lower limbs remained flaccid and areflexic, however minimal hip and knee flexion was noted. Bladder function was improving, and the catheter had been removed.



Discussion

This case highlights the need for caution when making the diagnosis of a simple febrile convulsion. The presence of a prolonged seizure, any lateralising signs or a Todd's paresis by definition make it a complex febrile convulsion which has prognostic implications (1). It should alert the clinician to the possibilities of structural brain lesions and CNS infections and the development recurrent afebrile seizures (2). Differentiating simple febrile convulsions from those associated with more sinister aetiologies can be extremely difficult, especially when the child has a past history of simple febrile seizures. Certainly further investigation is warranted in the presence of any atypical features, or if the child presents at a young age (less than 12 months). Most paediatricians in this country agree that in a first simple febrile convulsion in the absence of a demonstrable cause a lumbar puncture should be performed.

Pneumococcal infections are an important cause of morbidity in childhood. It remains the commonest cause of community acquired bacterial pneumonia in childhood. Other common conditions due to Streptococcus pneumonia that cause considerable 'misery' in childhood include otitis media and pharyngitis. Though most of these episodes are followed by a full and uneventful recovery, post streptococcal nephritis remains a potential complication. Following the introduction the conjugate Haemophilus influenza B (HIB) vaccine and the resulting decline in HIB meningitis, Streptococcus pneumonia along with Neisseria meningitidis have become the most prevalent causes of childhood bacterial meningitis. Though well recognised as a cause of septic shock in

childhood the incidence of pneumococcal septicaemia remains exceedingly low, primarily affecting immunocompromised patients. Children with sickle cell anaemia are particularly at risk.

This case illustrates the most severe end of the spectrum of streptococcal disease in childhood. Despite early and aggressive intensive care, instituted by the paediatric transport team, we saw a devastating progression from pneumonia to septic shock, meningitis with subdural effusions and subsequent hydrocephalus. What is alarming is the alacrity of the progression from a relatively well immunocompetent child to one who was critically ill in the space of a few hours, a phenomenon well known to paediatricians but which many junior staff may not fully appreciate.

References:

1. Verity CM, Ross EM, Golding J. Outcome of childhood status epilepticus and lengthy febrile convulsions: findings of national cohort study. BMJ 1993; 307:225-8

2. Lacroix J Deal C, Gauthier M, Rousseau E, Farrell CA. Admissions to a paediatric intensive care unit for status epilepticus: a 10 year experience. Critical Care Medicine 1994; 22:827-32.

Shane Tibby, Michael Marsh, Ian Murdoch.
Dept Paediatric Intensive Care, Guy's Hospital.

Nurses' League Reunion

Guy's Nurses go out in style!

Guy's nurses from all over the world crowded into Southwark Cathedral on Saturday May 11 to attend their Service of Thanksgiving and Commemoration for the Guy's Nurse. This was the start of a great day of reunion and commemoration following a ceremony the previous afternoon in Westminster Central Hall, when HRH Princess Alexandra had presented badges and certificates to the last young men and women to become Guy's Nurses.

Welcomed by the Canon Pastor, the 1200 strong congregation filled the magnificent building with singing, The Commemoration lesson was read by Staff Nurse Laura Jenkins (Guy's 1996), daughter of a Guy's nurse, and a passage from 'Matron of Guy's' by Emily MacManus was read by Miss Audrey Crump (Guy's 1947), long time Sister on the children's wards at Guy's, The Provost, Very Rev Canon Slee gave us a welcome opportunity to applaud this delightful account of the ethics of nursing at Guy's before his excellent address. The Nurses' League Choir with Kenneth Dougall as conductor, and augmented for this occasion by tenors and bases, excelled itself with Handel's Coronation anthem 'Zadok the Priest' The prayers were read by the Hospital Chaplain, The Rev. Neville Smith, who included the Guy's Prayer 'Bless, 0 Lord, those who have gone from this place to work in many different parts of your world'. After the Blessing the choir sang Rutter's 'A Gaelic Blessing' before the crowd filtered out into a dull, cool mid-morning to the strains of Widor's Toccata - enriched by a wonderful service and with promise of a great day. After picking their way through the Jubilee Line building site in St Thomas' Street, 450 of the nurses and their guests sat down to an excellent buffet lunch in the huge, decorated marquee erected for this great occasion in the hospital forecourt around the statue of Thomas Guy. Our

special lunch guest was thirteen year old Emily MacManus, great great niece of Guy's well remembered and much loved Matron (1926 - 1947). Emily came with her father and other members of her family and graciously made three presentations to senior members of the League who had recently retired and who had each known Matron MacManus personally. After lunch the Annual General Meeting of the League was held in the marquee with Professor Sir Cyril Chantler, Principal of UMDS, as the guest speaker. This was followed by tea in the Colonnade, prettily decorated with blue and yellow flowers on the pillars and the arches covered to keep out the strong cold winds.

An 'Exhibition of Nursing at Guy's 1726 - 1996' in the Robens' Suite was a very great attraction for everyone. There was no one at Guy's that day who did not visit it. Excellent photographs through the years showed Guy's nurses involved in many activities; they were there in rows at their Preliminary Training Schools and in their decorated wards at Christmas time; there were pictures of them in war time and on night duty, and of their Matrons and their Sister Tutors, many of whom were well remembered. There were also photographs of Residents' Plays and hospital pantomimes and many of us found pictures of ourselves there somewhere, at some stage of our youth. As well as samples of uniform and of needlework, there was an excellent written commentary of our training and work at Guy's around the walls. It was a truly commemorative exhibition and very much enjoyed.

View of congregation

In addition, the Royal Worcester porcelain Staff Nurse figurine was finally on show in her 1960s uniform, there now being very few of the limited edition

of 750 still available. In the lecture theatre a video of Mr Guy's Hospital was shown several times during the day. A historic Treasure Hunt had been meticulously compiled by Dr George Scott, the winner of which was Miss Barbara Hastings (Guy's 1949) who was sent two tickets for Les Miserables with our congratulations.

In the evening, nurses were joined by many Guy's men and women for a grand Gala Reception in the Colonnade. In the festively decorated marquee students from the Guildhall School of Music entertained us with a wind quintet during a buffet of international cuisine. Not for the first time Thomas Guy, this time tastefully decorated with flowers and ribbons, was surrounded by a crowd of Guy's revellers. Dr Bob Knight, Consultant Physician, welcomed the guests and told tales of days gone by - who better than he?

Emily MacManus, great great niece of Matron MacManus

As strains of the jazz band sounded from the Colonnade the dancers moved in to enjoy themselves, while in 'The Spit' the gamblers among us had fun on the gaming tables. At midnight as the dancing ceased the last of Thomas Guy's revellers drifted happily away with their commemorative gift.

It was a grand evening, the culmination of a great day, enjoyed by many generations of Guy's people. Sincere thanks are due to The Hospital Trustees for their generosity, and to The Friends of Guy's for donating and arranging the beautiful flowers. In addition we thank the very many others who did so much to make this a truly memorable day to give the Guy's Nurse a rousing send off.

Margaret Lamb

Churchill's Pocket Book of Surgery

The contents of this pocketbook are conveniently displayed on the front cover for easy reference. The author states quite clearly the aims and uses of the book, pre-finals cramming being one among many!

As with any pocketbook, the idea is to be able to look up an appropriate topic quickly and grasp a few facts in a short space of time (hopefully followed by more detailed reading; time permitting). This is definitely possible with this book as each chapter is clearly divided into subheadings, consisting of lists where necessary and including appropriate illustrations. Important definitions are boxed in red and after signs & symptoms and investigations have been dealt with, treatment and prognosis follow. The pocketbook seems to have all the basic information in a very readable format and certainly stands in good competition with other available handbooks. However, another characteristic of a good pocketbook is its essential supplementation with a more detailed text. Since this one would fit with almost any other surgical text, its use can only be enhanced and confidently pursued on the wards.

Churchill's Pocketbook of Surgery, A.T.Raftery, Churchill Livingstone, £13.50, ISBN 0443050570

SSJ

Histology

This detailed text boasts an approach suited to both students participating in the integrated course and in the traditional separate subject course.

Each chapter is packed full of information intended to be in a progressive form ie. cells through to tissue to organs and finally organ systems, thus allowing the reader to build up a microscopic image of the structures involved, as well as deriving a grasp of the functional aspects at each level. Although numerous computer generated diagrams are scattered throughout each chapter, the lack of original microscopic material is apparent and missed - for these, other books may have to be referred to. The straightforward layout makes it an appealing textbook to buy but it would be easy for the pre-clinical student to get bogged down by the detail. One of the alternative texts might be more appropriate for the depth of knowledge required at 1st and 2nd MB level, but of course, if you want a thorough account, this could be just the book for you.

Histology, Begman, Afifi & Heidger, Saunders, £20.00, ISBN 0721630898.

SSJ

Microbiology and Infection

This book seems to have been tailor-made by the author as a result of comments and suggestions from various students. A short and impressive section on using the book opens with an explanation of how it is laid out and how it can be used to varying depths.

There then follow some general tips on effective learning and what to do if you leave things until the last minute (ie. learning fast and picking out important aspects) - some very valuable points are made throughout. The first five chapters deal with basic microbiology ie. micro-organisms, normal flora, investigative techniques etc. The remaining chapters are based on systems and approached using the same format ie. epidemiology (where appropriate), pathogenesis, clinical diagnosis, chemotherapy, prevention, diseases & syndromes and organisms responsible. To get the most out of each chapter, a set of MCQs, SAQs, essays and case histories are included, with answers following immediately, to ensure that self-testing is not ignored. The text is well set out and easy to learn, much like the handouts that are available to those doing the final pathology exam. The book can be used by these students in addition to the handouts and can either serve to fill in the gaps that a lecture may miss or add to the information received. The price is more than reasonable for a book of this depth.

Microbiology and Infection, T.J.J. Inglis, Churchill Livingstone, £15.00, ISBN 0443050341.

SSJ

Back Issues

Back issues of the Gazette are availabe from the Gazette Office at a cost of £2 +p&p. There are limited copies of most of the previous issues.
Please contact the Office with your requests.

Holy Hearts

I was quite surprised by an article I read in the Nursing Times late last year. It was written by a professor of the philosophy of education at the University of London, and described his experience as a patient in a coronary care unit. He was quite satisfied with his medical care, but very upset that as part of a captive audience he was unable to escape a religious service in his ward.

He had collapsed on a Saturday and was 'wired up' to machines on the Sunday morning when a group arrived from the local evangelical free church. Hymns, prayers and a sermon on the moral crisis facing Britain followed. This patient described himself as a lifelong agnostic who was sure that this religious outburst did his physical health no good. He wondered how widespread the practice was. He asked if there were ever any objections. Another patient in his ward suggested it would be better if the service was held away from the ward, and sent out over the hospital radio for those wishing to listen and unable to leave the ward.

He felt he was being taken advantage of, and that this imposed service conflicted with the unit's philosophy: the health team had a concern for the autonomy of patients. As self-determining persons, patients should have the right to refuse being present at such statements of personal belief. He finally proposed as a seminar topic for Project 2000 students: should religious services in wards be abolished?

My initial reaction, as stated above was one of amazement that, in this day and age, the NHS permitted such goings on. I know hospital chaplains exist for those who want them, and are paid for by the NHS, but I was unaware that they ever imposed their views on anyone who does not invite them. I actually think parsons should be paid for by those who want them - but that's another story!

At Guy's years ago, Ward Sisters accompanied by their nurses, used to conduct daily prayers - a practice thankfully long discontinued. Furthermore, in our multi-faith society, it would seem unwise that any specific group should have the right to expound their views to patients too ill to leave their beds.

I was aware that some institutions still existing have a religious connection, despite gaining some of their funds from the public purse, but I hope most readers would agree that any attempt at forcing reluctant patients into accepting their ideologies should be resisted.

In the past many nurses came into the profession as an act of 'vocation'; presumably a call from someone or somewhere. But I think it is unlikely many students today see it like this. More commonly there is the simple wish to help other humans that inspires those who embark on a nursing career. A

common instinctive notion we all possess to a greater or lesser degree, and in different forms. Indeed, in years gone by, it is evident the 'vocational' image of nursing was often false; young women had little choice in the occupation they could pursue.

So hypocrisy existed, ward services were common, and even expected. But today, few nurses would accept this situation, and would I guess support our professor of philosophy in urging that religious services in wards should be abolished.

Otherwise we find ourselves in the same position as the editors of the BBC's Radio 4 'Today' programme, in which they are powerless, to prevent inclusion of 'Thought for Today' by the religious affairs department.

Folks ill in hospital come from a variety of backgrounds, and do not expect to be taken advantage of in their infirmity. I hope that permission to hold these bible-bashing occasions will not be granted. If patients feel the need for spiritual help they need only ask; forcing alien views on someone is surely more injurious than leaving them to relax and gain full benefit from the medical and nursing help they expect to receive while they are in a hospital bed.

Denis Cobell

Guy's Hospital - 250 years

Have you ever wanted to know more about the history of Guy's? What was student life like in the nineteenth century medical school? What happened in the Resident's Plays of the Forties and Fifties? How about nursing, midwifery, the Wills Library? Or the early days of X-rays?

This 240 page, illustrated paperback gives a history of the achievements in every field of Guy's life for the past 250 years, and is available for only £2.95, including postage and packing, from the Gazette office. The book makes an ideal gift, and only a limited number are available.

Please send cheques or postal orders, made payable to Guy's Gazette, to Guy's Hospital - 250 Years, Guy's Gazette, Boland House, London SE1 9RT

UNITED CLUBS UNION SHOP

Boland House
Guys Hospital
London SE1 9RT
Tel: 0171 955 5000 Ext. 5947

Opening Times: Mon, Tue, Thur 12:00 - 2:00pm

TIES	
Guys Crested - polyester	£ 6.00
Guys Crested - silk	£14.50
Guys Striped - polyester	£ 6.00
Guys Striped - silk	£11.75
UMDS - polyester	£ 6.00
UMDS - silk	£14.50
GUYS TIE SLIDE	£ 7.25
GUYS TIE PIN	£ 4.00
GUYS CUFF LINKS	£ 8.50
GUYS SCARF	£11.50
GUYS / UNIVERSITY OF LONDON SCARF	£11.50
GUYS ENAMEL BLAZER BUTTONS - 2CM	£ 3.40
- 1.5CM	£ 3.25
GUYS LAPEL BADGES	£ 3.00
GUYS SWEATERS (Several colours)	£23.00
GUYS SWEATSHIRTS (All colours)	FROM £15.00
HOODED SWEATSHIRTS (Large or small crests, assorted colours)	£16.00
GUYS T-SHIRTS (All colours)	FROM £ 5.00
HONEYCOMBE T-SHIRT	£12.25
HONEYCOMBE COLLARED T-SHIRT	£14.75
POLO SHIRTS	£11.25
1/4 RUGBY SHIRTS (Navy/Bottle Green or Navy/Maroon with white collar. With Guys crest)	£15.25

POSTAGE & PACKAGING:
£1 For large items, 50p For small items.

Margaret Fendick
Shop Supervisor
February 1996

Terence Robert Launcelot Finnegan, MD FRCP

Terry Finnegan came from a medical family. His father was a general practitioner in Sanderstead and his two elder brothers became doctors. His own inclination to follow in their footsteps became plain when he started school at Epsom College. There, his fine physique and long legs won him success in athletics, especially in the 220 and 440 yards and his personal qualities made him Head of School.

He came to Guy's in 1941 when the Medical School was evacuated to Tunbridge Wells and he took his responsibilities as a war time student very seriously. After qualification and house appointments at Guy's he did his National Service as a Medical Officer in the Royal Air Force and continued as a volunteer long after demobilisation, being stationed at Biggin Hill. On return to Guy's, he chose to train as a general physician ascending through the registrar grades to become Clinical Tutor, a role which he especially enjoyed, and he will be remembered by many Guy's graduates. He broadened his experience by spending a year as a Research Fellow at the Johns Hopkins Hospital. In 1959 he was appointed consultant physician to the Derbyshire Royal Infirmary - a hospital well accustomed to having Guy's men on its staff. In addition to his general medical duties, he took on the responsibilities for most of the geriatric beds in Derby, which involved him in an enormous amount of work and which he continued until 1966 when a new appointment to the staff was made. He retained a warm affection for Guy's with a deep loyalty to his old hospital. He continued the tradition of bedside clinical teaching for the benefit of countless registrars and house physicians and maintained an especial interest in gastrointestinal medicine. He never counted his hours at the hospital and earned the deep respect and affection of patients, relatives and the nursing staff. His fellow consultants found him to be a most admirable colleague. He enjoyed country pursuits and his interest in biographies, classical music and the arts shaped his leisure hours and his elegant home and garden. He coped with the painful and protracted illness with great courage and firm faith, wonderfully supported by his friend, Jonathan Halbert, and died on 16 March 1996.

Michael Leveaux, George Scott

If the World is Your Oyster....Can GradSoc be Your Pearl

For the last three years you thought college was something a bit special, but now you know that if you can just make it through finals, an even more fabulous life lies before you; an orgy of fun, freedom, fame, wealth and success.

OK, so its a bit over the top. Still, even if finals pressure hasn't sent you spinning off into deranged fantasy, with so much to look forward to why is the news all so gloomy? Unemployed or in a dead end job, defaulting on loan payments, losing touch with friends and forced to live at home again, this is the image so often portrayed of Graduate life.

Whatever may be waiting for you on the other side, however, there are certain things you can still rely on. One of these is the University of London Union (ULU). By joining as a Graduate member you can still enjoy all that ULU had to offer you as a student. Access to the fitness centre, swimming pool, sauna, treatments, classes and other sports facilities; use of the bars, restaurants, stationary, and sports shops all of which charge student prices; confidential advice from the welfare unit; and the chance to join any of ULU's varied societies and sports clubs. With the return of ULU as a major gig venue, the ULU ticket shop is by far the cheapest place in London to buy tickets.

The Graduate Society isn't just a membership scheme for ex students though, it's also a social society established to address the particular needs of its Graduate members. The 'GradSoc' newsletter produced twice a year contains relevant news, information on members, a graduate careers section, features, articles and an international section. Even if you move away, the newsletter can help you to stay in touch with university news and issues of interest to you.

If you are intending to stay resident in or around London, you'll also be able to enjoy the events on offer. Wine-tastings, theatre trips, a day out in Kew gardens, a comedy evening and speakers on UFO's and pagan religion were amongst the event organised in the last year or so.

As part of the commitment to provide the practical support which graduates need, now more than ever before, networking and careers events are currently being planned, while suggestions for other possible graduate services are also being considered.

Finally, and more importantly, the Graduate Society encourages involvement. All contributions to the production of the newsletter are enthusiastically received, while administrative and financial support is available for any member keen to host a particular event. Members are also en-

couraged to join the steering committee or to simply go along to meetings and join in.

So, don't listen to the pessimists and alarmists! Step confidently in Graduate life with the security that ULU will always be there for you.

The very best of luck for exams and the rest of your life.

Membership of the ULU Graduate Society costs just £10 per year (£12.50 EU, £15.00 rest of the world) and is open to all ex-London Students. Watch out for the application form with your degree certificate, pick one up from Reception, ULU, Malet Street, London, WC1E 7HY, or phone the Graduate Society office on 0171 580 9551 ext. 239

Summer Charity Ball 1996

The 1996 Summer Ball is to be held in the tradidtional grounds of Cobham. This year's events include Hot Air Balloon rides, a Carousel, Clay Pigeon Shooting, and Pulsar amongst other things. As usually food will be on hand in the form of a B-B-Q.

This years recipient charities will include the Arthur Karre Baby Unit at Guy's Hospital and also the Stroke Unit at STH.

For those interested tickets can be purchased, at £40 per ticket, by application to the Summer Ball Committee, Beadles Office, UMDS, St. Thomas' Hospital, Lambeth Palace Road, London SE1.

Rugby

Guy's 1st XV v Purley
Courage League HOP
Won 20-19

For the last league match of the season, Guy's entertained Purley. At this time in the season both sides were in mid table and were safe from relegation but without prospect of promotion either.

Traditionally Purley play with a large set of forwards and in previous years a 10 man game had been their norm. In a fairly inauspicious start Purley used the driving maul to good effect but after Guy's dad dropped the ball in the centre Purley launched a series of attacks on the Guy's line. However, the Guy's defence was excellent and they kept the larger Purley attack at bay but were eventually caught offside and the penalty was accepted by Purley. Guy's then settled down to some marvellous open play, moving the ball from side to side on a dry ground and Jenkins went over for a well deserved try. In the absence of Neil Davies, kicking duties were taken over by Ugo Ekowa and although he missed the conversion from wide out was successful shortly afterwards with a penalty. For the rest of the first half Guy's were on the attack but it seemed that in the final moment of scoring the ball was lost. Both Hostert and Breeze were close to scoring but just before half time Purley got a second penalty when Guy's were penalised for going over the top in front of their own posts and this left the half time score as 8 - 6.

However the story of the second half was rather different with Purley taking control through their forwards and their monopoly of possession took the score to 19 - 8. the final stage of the game however was transformed when Guy's suddenly took the score to 19 - 8. The final stage of the game however was transformed when Guy's suddenly got a new lease after Rose at full back was stamped in the nether regions and for the second time in the season what a benefit to a side this could be. First of all Ugo Ekowa smuggled the ball away from the lose maul and raced over for a try under the posts which he converted to take the score to 19 - 15 and then a period of Guy's pressure Challacombe crashed over for an unconverted try to take the score to a very exciting 20 - 19 for the last 10 minutes of the game. So, Guy's ran out slightly fortuitous winners by one point to the dismay of the Purley supporters many of whom had been very vocal in their advice to the referee, much of which he had apparently accepted. For Guy's the forwards played well to the referee, much of which he had apparently accepted. For Guy's the forwards played well as a unit and supported each other in the face of some fairly robust charges from the opposition. Barrio and Cocks in the line out won a considerable amount of ball. In the backs Jenkins at centre had

another fine game with many storming runs through the middle and even the wings got a share of the ball.

The win meant that Guy's finished joint fourth in the table which is easily the highest of any hospital side.

Team: Baladasaran D, Evans D, Hostert L, Challacombe B (Capt), Barrio E, Ryan G, Davies P, Cocks J, Davies J, Brown R, Breeze R, Jones A, Jenkins G, Ekeowa U, Rose M.

SJC

3rd XV v The London Hospitals' Cup - Semi-final
HOP - Result Won 39-0

A few years ago United Hospitals instituted a Hospitals' Cup competition for 3rd XVs to add to those for the 1st', 2nds' and Ladies' XVs.

The competition was received with much enthusiasm since it allowed more members of the rugby playing fraternity to meet their counterparts at other hospitals and, more especially, to savour that unique partisan competition which is the Hospitals' Cup rugby. The cup has resided with Guy's since the inauguration competition and, as a result of this game, Guy's were once more in the Final. This game was noticeable for its pace, enthusiasm and a great deal of skill. The 3rd XV is a mixture of experienced older players who have represented the Club at the highest levels and more recent members of the student body, and this mixture of the old and the new has been one of the strengths of Guy's rugby over the last few years. Given that the game was played immediately after several hours of persistent rain, the open rugby displayed was impressive. Guy's really had the match won by half time by which they had scored 5 tries and, although The London came back well in the second half, they were never able to win sufficient ball apart from their lineout to seriously threaten the Guy's line and two tries by Guy's saw them home.

For Guy's the pack looked efficient in the loose where Williams, Smith and Russel were usually first to the breakdown and played with great pace. Richard Docker at stand-off once again showed what a natural player he is, handling and kicking with authority and releasing the backs time and time again on exciting attacks. At full back Norman had a storming game. Overall the match was notable for the commitment of all 15 players.

Scorers: Smith 2, Williams 1, Slater 1, Conversions: Williams 3.

SJC

Football

2nd XI Football - Season Report

The 2nd XI were a bit of an unknown entity this year, no one quite knew what to expect, but fortunately, much like the squad in general, they were boosted by numerous freshers, (a case of quantity rather than quality).

The season started quite well with a strong team which had old war horses Riki Trivedi (Captain) and Neil Guha , both leading the team from the back. The heart of the midfield was run by freshers, Chiddi (Chiddi run?) and caveman Khurram, who remained strong and skilful all season. Two able, if not slightly older, wingers Ranju and Niffio, along with Mr 'Reliable' Imtiaz added some creativity and zip to our game (but not much). With fresher Ross, not so fresh Ollie and very fresh Squash putting the ball away up front, or not as the case seemed to be. The defence was being well marshalled by superfit 'Bluebeard' and 'Brains from up north' Mike (how the **** did he get into Cambridge) Borough and Lai-(penalty expert) Hok, with 'smooth' Argi between the sticks.

A cheeky St. Georges' side were played a number of times, with resulting stalemates, before the team was strengthened further by new recruitments from the freshers' tour. 'Destructive' Iranian pair Abtin 'Scudster' and Mahyar 'Kebaby' who were both scouted by Guha, who admired their vomiting on the train up to and down from Nottingham, as well as a versatile assassin Alexis 'Vinny' Vincenzo, who played goalie and down the left, destroying many an unsuspecting right midfielder with his 'uncontrollable' left foot. Also adding to the squad was Southend stunner Mark 'Shazza' who covered at right back for both our captains', whose dogdy right knees hindered them for parts of the season.

Just as the season and the side were looking on course for a triple Championship winning year, disaster struck from all sides. Argi's back injury put him out for 3 months, Lai-Hok, Neil and Riki were all lost to International duty. Redbond and Ross were lost to the 1st team and Vinny and Mark to the 3rd's. Imtiaz was also lost to part II exams, leaving a very depleted side lacking in confidence, experience and age but more than making up for it in style, skill and fiery passion (unfortunately usually too much of the fiery passion). Unfortunately the losses especially in goal made things quite difficult, forcing us to play 9 different people in goal: Lai-Hok, Kebaby, Neil, Riki, Smokey, Vinny, Rammy, Nidge and even 'Jimbo flapper' himself Matt Baltitude. We nearly even played Bob Gerber there just for the sheer size of his bottom and the fact that that alone filled the goal, but then again so did Kebaby's, Nidge's and Balti's so we saved Bob's buns to maraud all over the field.

The side took on a very very young look, fresher Nav was draughted into the side to play alongside fresher Squash. 'Dependable' Nis also another new fresher recruit was added to Solid left winger Scud, (shame he doesn't have a left foot), Chiddi (umbongo drums) and Khurram (come-on!), in midfield to give us one of the most well oiled midfields in the league, the grease on those boys was more than that on Noely's chops after his 3rd meal down at Cobham. Fresher James 'baaaa' Powell, later known as quick-draw (for his lightening Fowler-esque strikes) was also added to the back to join stand-in captain Kebaby. Cambridge boy, 1st year at UMDS, Mike Borough (I can't play at week-ends because of my flange) was very solid at the back, that is when he wasn't flanging.

The team battled (more with their fists than their feet, although there was the odd stamping incident), and to their credit got to the UH quarter final, a heart-breaking UL semi-final which was only lost 9-8 in a penalty shoot out after extra time and was only 2pts behind the leaders in the league with 3 games in hand at one stage. But with every game they became more and more weary and eventually their spirit broke. When they started 'lending' players to the 1st's and 3rd's every game leaving themselves short the season really was over.

Even though the season was slightly short on the old silverware it was a particularly memorable year for a number of special memories:

(in no particular order of preference) :- Chiddi's great right foot, which struck many a sweet pass, and his great right hook which struck Andy in the UH quarter final.

- Kebaby's passion for the team and his numerous sendings off. Including getting sent off twice in his first game for the 2nd team and in the semi-final of UL in his first game as captain. And his threats to violate the referee's orifices against Charing X.
- Riki's grace in goal.
- Neil's grace in goal.
- Vinny's grace in goal.
- Vinny's grace on the pitch and special thanks to the referee for allowing for his clumsiness.
- Argi's penalty saving.
- Khurram's penalty taking and the Gazza like tears that followed his miss.
- Lai-Hok's penalty taking which cost us the UL cup.
- Kaveh's vomit on the pitch.
- Kaveh's 2nd vomit in the same game.
- Jimmy Allen for being Jimmy!
- Scud's orgasmic cramp and him crying out 'harder Chiddi, push harder!'
- Nidge moonying George's in the penalty shoot out when we hadn't won yet,
- The Halal boys praying before the kick off.

- James' goal celebrations.
- Noely playing left wing.
- Bob Gerber in general but especially for his school boy smile and giggling the whole time in Amsterdam and his introduction of the game 'Plumbmaster' on the ferry home.
- But most of all, for the 3rd XI losing (really getting destroyed, 6-1,) in the UH cup final, 'class really showed'.

Just leaving the question 'How much did Skizaz pay Fingal to leave the 2nd's in the lurch the one and only time they needed him?'

I hope we have a solid season next year, already looking forward to the freshers tour.

K E Bab

Hockey

The Spirochaetes Hockey Tour 1996

After several years of rather poor results, the Spirochaetes met for the journey down to Paignton full of confidence as we really felt that we had one of our best teams for many years this year.

It's a long journey down to Paignton, but it's amazing how quickly the time passes when everyone's singing in the minibus!

Although a few tired legs were evident on the pitch as a result of a mega-Trivial Pursuit session in the hotel the night before (Steven "I'll have an orange pie" Pryke being the worse culprit), we gave a reasonable performance in the first half of our match against The Kismets, although the score of 3-0 flattered us a little. Continued pressure in the second half and excellent defensive work from Guy and Billy saw us win 4-0.

After a team visit to Paignton Museum, we played our second match against The Pederests (last year's winners). Not really a match that we were intending to win, and we probably wouldn't have done without Zaheer, who showed the form which has made him a county player and scored a hat-trick. Other goals were scored by Ed Sharples, Ian Griffin (2) and Steven Pryke (pen. flick). 7-0 and probably the best performance by a Spirochaetes team for several years.

On paper, our draw on Saturday was easier. We played The Rabbits in the morning, who finished bottom or the tournament last year. True to form it was a rout: 9-2 with Gardner getting four excellent goals. The Hairy Marys were a different proposition altogether. Despite relentless pressure for much of the half, we ended the first half 1-0 down. A goal straight from the restart by a much improved Chris Barry meant that we were in for an exciting half. However it was not until the last minute when Pocock picked up the ball inside

our own 16, left four Hairy Marys standing and scored a quite magnificent solo goal. 2-1 Spirochaetes.

As ever, we had only one match on the Sunday - against The Starfish, which we won easily 5-2. Word came from the Festival Organisers that we were tied with The Bullies for The Bill Stickles Cup - a trophy presented to the side scoring the most goals in the tournament.

Despite the Captain's protestations, seven of the team went for a slap-up meal that evening, and said that they were in bed before midnight - and who are we to dispute it!

We took the field for the last match on Easter Monday against, yes, The Bullies! Basically the winning team were to take the trophy. Understandably both teams seemed a little affected by the stakes and a rather lacklustre first half ensured. The only exception was play of Ben Eddy and Ross who combined well down the right flank to create our only two real chances.

The second half saw a far better Spirochaetes performance and finally we started to take control. It was rather fitting that one of the most experienced Spiros - Chris Pocock - should set up a winning goal for next year's Captain, Steve Pryke. Result 1-0 and The Spirochaetes had won The Bill Stickles Cup for the first time in their 37 year history.

Congratulations to all those involved - hope those hangovers were not bad on the Tuesday! See you next year!

Squad; D. Harrison (Captain), E. Rytina, I. Phipp, T. Gardner, C. Pocock, V Gradillas, R. Hatrick, I. Griffin, S. Pryke, G. Barwell, B. Jowett, B. Eddy, E. Sharples, D. Quick, K. Ong, Z. Yousef, C. Barry, Ross, J. Pitman.

Sailing

Staff vs. Students Sailing Race Seaview Yacht Club - Isle of Wight 30.6.95.

The fourth annual staff vs. students race was looking surprisingly good with forecasts of sunshine, winds force 4 - 5, and the unusual arrival of all students at the right time and in the right place (almost Mikey).

B and B's acquired we took refuge on the balcony of the Seaview Yacht Club in idyllic conditions, the tension of the forthcoming racing apparent as dry throats seemed virtually impossible to moisten. As talk turned from finals just gone to questions of 'what's the pointy end of the boat again?' or 'how do you drive those things?', we began to wonder once again just how much of a threat we were to the staff. Plan B was thus borne - make sure they feel worse than us tomorrow morning.

The evening continued smoothly until after the excellent dinner, where Prof. Sonksen once again started the joke telling. It began with relatively

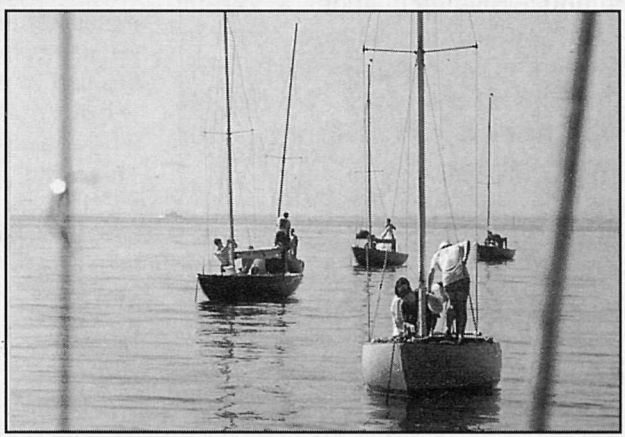
tasteful jokes, relative of course to the jokes and stories that soon began to follow, and finalised as it started with Peter's 'Piece de la resistance' - unrepeatable at the best of times let alone now. With the crews planned, and the donation of one student to the depleted looking staff teams the evening drew to a close.

With true to form forecasting style the Met office was only half right; yes the sun was shining, but no the wind was far from blowing. After the debriefing where the Yacht club drummed in the 'Non-contact' part of this sport we took to the water, any of the student helms having to tell their crews the intricacies of flying a spinnaker for the first time (the lack of wind making the responsibility rather easier). The staff cunningly took advantage of this as the first race was started with many of us well upwind of the starting line. This made for a particularly sociable race, running back down to the line past the staff boats beating to windward (putting a smile on many faces).

Unfortunately it is at this point where we run out of excuses, yes, the staff won this race, and unfortunately the next. And just scraped wins in the two races after lunch. However, once again the students felt they could take the moral victory.

It was a superb day, the tide having perhaps more effect than the wind, but this took nothing from the enjoyment of the sunshine which lead to swimming in the Solent once again. Thanks must go to the Seaview yacht club, for the race organisation and excellent food, Prof. Sonksen for organising the weekend, and to the rest of the staff for their generosity and sportsmanship. I'm sure this weekend will continue to be as successful in the future as it was this year, perhaps in the future we will be able to recruit some sailors to place more of a threat to the staffs winning streak (but where is the fun in that?)

Guy Barwell



Deaths

Brotherton, RWF qualified LDS RCS. Passed away in his 88th year. Qualified from Guy's in 1931 and was very proud of his association with his *alma mater*.

Webb, Dr Robert Arthur John. Died in Australia, 31st March 1996. Graduated from Guy's in 1951.

Notification of Death

The Gazette makes no charge for printing notices of deaths or obituaries. If you would like to have such a notice included about a former Guy's affiliate., please send in either a typed copy or clearly written copy of the notice. We request that all obituaries should be typed or word processed.

Bournemouth and Wessex Guy's Hospital Society

It is an honour to have been elected Chairman of the above Society for 1996. I am writing to the Gazette to remind all Guy's Doctors and Dentists who live in the Hampshire, Dorset and Wiltshire areas that the Annual Dinner will be held on Friday, 1st November, 1996, at the Durlston Court Hotel, Bournemouth.

The Honorary Secretary, Mr Eric Archard will be organising the dinner, and anyone interested in joining the Bournemouth and Wessex Guy's Hospital Society should contact him.

I shall be delighted to have a good attendance at the Annual Dinner, it is always a very enjoyable evening, and an excellent opportunity to meet old friends. We have a faithful group or regulars, but will welcome new faces, and there must be many ex-Guy's in this part of the Country. Please join us.

Eric Archard's address is 1, Beechwood Avenue, Bournemouth BH5 1LX, and telephone number 01202 393077. He will welcome a letter or telephone call.

Ivor Broomhead

Guy's Hospital
MEMORABILIA

Unique items available only from the Gazette

Specially made, limited edition Guy's crested car badges. Grey background, black shield with silver lions, gold crowns and blue fleur-de-lis on a gold chevron. The motto is displayed on gold scrolls with black lettering. Frame forged in solid brass finished with deep chrome plate.

Price £25 each + £1 p&p

To: The Manager
Guy's Hospital Gazette
Boland House
St Thomas' Street
London SE1 9RT

I enclose a cheque/PO for £ .....
NAME: .....
ADDRESS: .....
.....
.....

Please make cheques payable to Guy's Hospital Gazette

Office hours: Monday to Friday 1-5 pm. Personal callers welcome.

Changing Your Address?

Please give us SIX WEEKS' NOTICE of your move. This will help us to make sure your *Gazettes* continue to reach you.

PRINT YOUR NAME AND **OLD** ADDRESS	NAME	
	OLD ADDRESS	
	TEL.	POSTCODE
THEN PRINT YOUR NAME AND **NEW** ADDRESS HERE	NAME	
	NEW ADDRESS	
	TEL.	POSTCODE

Now cut out this coupon and send to:

Guy's Hospital Gazette
Boland House
Guy's Hospital
London Bridge
London SE1 9RT

GUY'S HOSPITAL GAZETTE

UMDS Guy's
12 AUG 1996
Library

July 1996

- Interview with Professor Williams
- Sir Astley Cooper
- Guy's Hospital Staff Round

Guy's Hospital MEMORABILIA

Unique items available only from the Gazette

Hand painted Guy's crests mounted on a selection of woods. These make ideal gifts for any Guy's man or woman. Just what you need to decorate your surgery or study!

Price £25 each + £1 p&p

To: The Manager
Guy's Hospital Gazette
Boland House
St Thomas' Street
London SE1 9RT

I enclose a cheque/PO for £ .....
NAME: .....
ADDRESS: .....
.....
Tel:.....

Please make cheques payable to Guy's Hospital Gazette

Office hours: Monday to Friday 1-5 pm. Personal callers welcome.

CONTENTS

242 Passim
243 **Letters**—Nurses Cry Out, Tory Blues
246 **News**—50 Years Up
248 **Feature**—Ethics & the Curriculum
254 **Feature**—Interview with Professor Williams
260 **Feature**—Astley Cooper
268 **Feature**—Guy's Hospital Staff Round
278 **Reviews**—Immunobiology, Cognitive Therapy, Physiology
281 **Obituaries**—Eric Dann, Bruce Wotton
283 **Sport**—Rugby, Boat Club
288 **Classifieds & Announcements**

Guy's Gazette

Editor Rikin Trivedi **Assistant Editors** Paul Hayden, Barney Scholefield **Sub Editor** Sue Ferguson **Features Editor** Kate Mundray **Review Editor** Susan Jain **Sports Editor** John Davies **Nursing Notes** Denis Cobell **Office Manager** Margaret Flanders.
Acknowledgement Dean Flanders.

The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

Volume 110 Number 2458 July 1996
ISSN 0017–5870

Guy's Gazette, Boland House, Guy's Hospital, London SE1 9RT.
Tel (0171) 955 5000 ext 5413. All rights reserved.

Printed by Hobbs the Printers Ltd, Brunel Road, Totton, Hampshire SO40 3YS

Passim

In the late 1940s two of the most significant milestones in modern medicine were attained. Firstly, the introduction of penicillin in to clinical practice (1946), which single handedly armed the clinician with a drug that treated many deadly infections. Secondly, the formation of the National Health Service (1948), which was founded to provide and cater for the health requirements of the entire population.

In respect of the former, the pharmaceutical industry has grown to such strengths that the emphasis on therapy is now shifting away from antibiotics and towards genetic manipulation strategies. Whilst this is clearly being heralded as an advancement in Science and Medicine, the same can not be said of the seemingly downward direction of today's NHS.

Our present Government appears to be destroying the founding principles of what was once the envy of health care services world-wide. By closing more and more hospitals this admininistration has reduced the once easy access to the health care system and by forcing economics in to the infra-structure has created a generation of dictating pen pushers who seem to be skilled at putting a price to every life.

The Government will argue that competition only results in improvement. Probably the best example of this would be the increasing magnitude of statistics that we are now being subjected to in the form of performance tables. Statistics have left this Government blind to the reality. We are losing the NHS to penny pinching bureaucrats who have very little insight in to the real problems. If the NHS is to survive things must change.

When we enter our profession we undertake an oath; we vow to do what is best for our patients, without bringing harm to them, and to inform them honestly and justly to allow them to make a choice. Wouldn't it be interesting to see how Government would function if it set itself morals of equal stature?

Nurses Cry Out!

Dear Sir,
May 11th must have been one of the most thought-provoking days for all of us who experienced the overwhelming, standing-room-only response in Southwark Cathedral and attended the AGM of the Nurses League that afternoon. In fact my thoughts have been so provoked that I am absolutely livid that Guy's was 'set up' from the beginning, first as the Flagship Trust and then as the 'fall guy' in the NHS restructuring programme.

The address to the 95 AGM by Professor Hughes, fully reported in the current journal, set out in detail events affecting the status of Guys since 1991. Professor Chantler, as guest speaker on May 11th, compounded the pessimism voiced a year earlier with news of fantastically (I really DO mean fantasy world) escalating costs of the original Phillip Harris House due to faulty copper pipes - is this the water system? Surely this cannot be the only cause. Who is to blame - planners, a computer, contractors, manufacturers - they should be named and bear the added cost. Is it deliberate sabotage to finally finish off the hospital? Was the hospital manager, replaced three years ago, sacked for working against the interests of the hospital or the reverse? Will the probable demolition of Hunts House result in a multi-storey car park (we must all agree that the old building is well past its sell-by date) and to what uses will the Tower and New Guy's House be put if all in-patient care is transferred. Will Nuffield House be affected by BUPA's plans to stop using NHS units and what is the Cancer Research Councils' response, as well as that of Phillip Harris himself, to the phase III building fiasco? What has happened to the Save Guys' Appeal, surely a statement in all the national papers is needed considering the massive response the appeal generated. The inevitable publicity of medical breakthroughs and hi-tech developments makes us all expect tip-top healthcare whether in hospital or the community. Lack of nurses ie FUNDS TO PAY THEM, results in temporary or permanent closures of modern units at all hospitals and longer queues. The response to The Daily Mirrors' recent 'Save our Nurses' campaign should not be ignored in the first 5 year review of Project 2000 nurse training. There can be no quarrels with nursing school amalgamations if, after 2 years theory, the students can 'take' the practical realities of real nursing and the wastage is stemmed. A quote from the Gration/Holland textbook that the comfort and well-being of the patient override all other considerations and customs applies to all present day nurse functions, including directing todays bed-making ancillary staff that 'the aim of bed-making is to make the patient com-

fortable and not to make the bed tidy'. Pat Lelliot and myself rounded off the 11th at the Ray Cooney farce 'Funny Money' showing at the Playhouse, somewhat appropriate as it seems money has been thrown around willy-nilly in the healthcare sector generally and in the wrong direction in many cases. The word 'trust' in all its meanings has been brought into disrepute. I for one thought a hospital Trust was to be self-governing and with basic state funding, self-financing with minimal Whitehall interference. Good Luck to Barts if it can be saved by the City financial institutions but Guy's appears to have been duped by the 'flagship' accolade, used as an experimental guinea pig and then abandoned.

I do hope some of the questions raised in this letter can be answered in the next journal although a year will have elapsed and in spite of what I have written the planning and preparations by all the A-teams involved was most sincerely appreciated on May 11th.

Yours faithfully,

Beryl Fawcett

Tory Blues

Dear Sir,

Three hundred years ago the Tories lost the seat at Tamworth, Staffordshire, to Thomas Guy.

One would like to think that Mr.Guy, who sat as the Whig MP from 1695 to 1707, is looking down with satisfaction at the by-election result (report, later editions, April 12). He would certainly be very angry with the present Government, which is trying to destroy the hospital he founded and endowed.

R K Knight

(This letter is a reproduction of the original which was printed in the Times on 14th April 1996)

Letters

We would like to hear your views on any issues raised in any of the Gazettes, or anything to do with Guy's. You may have an opinion you would like to share with the rest of the readership. We would like to see some of your points published in future issues. If you feel you want to air your thoughts please write to the editor.

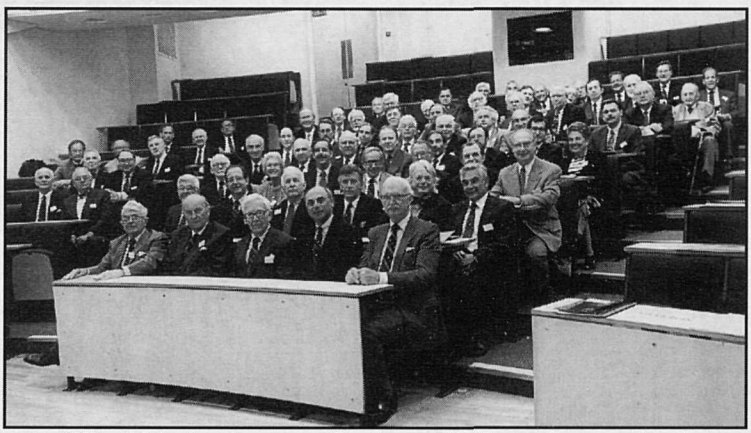
You are reminded that it is at the editor's discretion whether to publish a letter and that derogatory personal references to any individual will not be acceptable. We will however do our best to let you have a say.

50 Years Up

June saw the commemoration of the fifthtieth anniversary of the exchange programme between UMDS and the Trust and our transatlantic partners, Johns Hopkins Hospital. The event was celebrated here at Guy's in the form of a special three-part symposium entitled 'Molecular medicine: the challenge, the promise and the reality'.

The symposium which centred around a very important and indeed integral theme in modern medicine, was well attended by former exchange fellows, staff, scientists and other interested people from both sides. Guest speakers included prominent members of both countries governing health services as well as leading authorities in Medicine and molecular science. The symposium was opened by the heads of the two medical schools, UMDS Principal Sir Cyril Chantler and Johns Hopkins Dean Dr Michael Johns (both former exchange fellows)

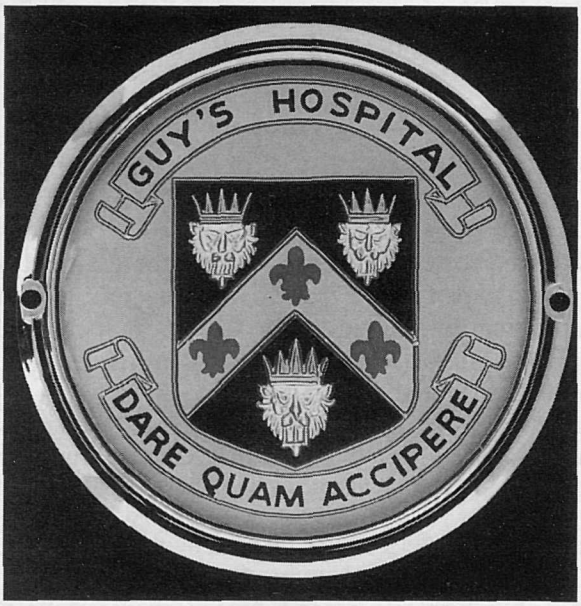
The two-day event although predominantly intense discussion was intermixed with a well organised social schedule which included a gala dinner and a cruise along the Thames. The event was rounded up with promises of continuing the excellent relationship between the two sides and hopes that the promises discussed would come through in to reality by the time that the next fifty years were up.



'The 50th Anniversary Exchange Fellows Symposium'

Guy's Hospital
MEMORABILIA

Unique items available only from the Gazette



Specially made, limited edition Guy's crested car badges. Grey background, black shield with silver lions, gold crowns and blue fleur-de-lis on a gold chevron. The motto is displayed on gold scrolls with black lettering. Frame forged in solid brass finished with deep chrome plate.

Price £25 each + £1 p&p

To: The Manager
Guy's Hospital Gazette
Boland House
St Thomas' Street
London SE1 9RT

I enclose a cheque/PO for £ .....
NAME: .....
ADDRESS: .....
.....
Tel:.....

Please make cheques payable to Guy's Hospital Gazette

Office hours: Monday to Friday 1-5 pm. Personal callers welcome.

Ethics & the Curriculum

Are we getting enough of it?

There was a time when it was assumed that all doctors knew what a 'good' doctor was. The questions of 'What is a good doctor?' and 'What should the good doctor do?' simply were not asked. Today this is no longer the case and the need for ethics to be a part of the training of doctors is not disputed. What is disputed are the questions of how much, what sort of training and how can the training be assessed by the time that medical students graduate. These same questions apply equally to dentists, namely, 'What is a good dentist? and 'What should a good dentist do?'

The pressure for change has come from a number of sources; from grass roots as well as from the top of the medical profession as well as from the public at large who are both intrigued and sometimes frightened at the issues that medical science and practice have to face.

Change from the top of the medical profession can be seen by the importance attached to ethics and law by the GMC illustrated by the quotes below:

Tomorrows' Doctors (GMC Dec 93)

§9, p.4 A forward look must . . recognise that the doctors of tomorrow . . will be confronted with as yet unforeseen moral and ethical issues arising from the scientific advances that are to be anticipated. Undergraduate education must provide at least an understanding of the principles on the basis of which such issues can be tackled.

§40.3 (b) p.15 the recognition of patient's rights in all respects, and particularly in regard to confidentiality and informed consent;

§40.3 (e) p.15 awareness of the moral and ethical responsibilities involved in individual patient care and in the provision of care to populations of patients; such awareness must be developed early in the course;

§40.3 (f) p.15 awareness of the need to ensure that the highest possible quality of patient care must always be provided

§49 pp.17/18 Man in society: Ethics and the legal aspects of medicine will be included

Annex A *Attributes of the independent practitioner*

§7 p.26 The ability to recognise and analyse ethical problems so as to enable patients, their families, society and the doctor to have proper regard to such problems in reaching decisions; this comprehends:

(a) knowledge of the ethical standards and legal responsibilities of the medical profession;

(b) understanding of the impact of medico-social legislation on medical practice; and

(c) recognition of the influence upon his or her approach to ethical problems of the doctor's own personality and values.

The duties of a doctor registered with the General Medical Council GMC (28/6/95)

This booklet is almost entirely made of moral considerations surrounding medical care.Outside the medical profession there is also pressure to ensure that Medical Schools address the questions of 'What is a good doctor?' and 'What should the good doctor do? The Patients' Charter implicitly addresses the question. Media coverage takes a keen interest in ethical issues that arise within the practice and delivery of health care as can be seen in the numerous television dramas as well as dedicated pages in the broadsheet newspapers and 'agony aunt' or 'Dear Doctor' columns in the tabloids.

Often the assumption is made that we as a society are clear about what ethics or morality is. It is assumed that we not only all know the difference between right and wrong in the moral sense, but can reach agreement. Whether this was ever the case is debatable. What is not debatable is that within contemporary British society there are a number of views as to what is morally correct and hence there arises fundamental disagreement and confusion.

Part of this confusion lies in what ethics actually is. I find it helpful to recognise three different branches or types of ethics:

First, there is '*normative ethics*' which deals with questions as to what is right and good. In other words it addresses the question of how we *ought* to behave. This branch of ethics deals with day to day situations and has spawned numerous sub-classes of applied ethics such as medical ethics, dental ethics, health care ethics, nursing ethics, research ethics, business ethics, marketing ethics and so on.

Secondly, we find what may best be called '*descriptive ethics*'. This branch of ethics looks at questions as to the answers given by particular societies and people, their religion and culture, to the questions that normative ethics raises. Here the student is looking into the affairs of others with a certain objective detachment. This branch of ethics is more closely related to moral sociology and anthropology.

Thirdly, we find questions as to the meanings or uses of the words used in answering questions of normative ethics. These questions address *the nature or logical character of the moral concepts*, or, in older language, of what goodness, truth, values etc. actually are. This branch of ethics has a number of labels such as 'theoretical ethics', 'philosophical ethics', or '*moral philosophy*'.

Medical ethics, as stated above, is an application of normative ethics within the context of medical practice. Can normative ethics be taught? The short answer is 'not directly'. A precondition of effective normative ethics is some mastery of both moral philosophy and a working knowledge of the dominant contempoary beliefs within our society. Descriptive ethics, though, can be taught, for example, studying what Christians or Moslems believe to be right or wrong or how the Kikuyu tribe regulates its people. Likewise the philosophical side can be explored by studying the writings of those who have already addressed the questions that theoretical ethics raise. Here the student is looking for coherence and consistency in the thinking of others which then acts as a springboard to further thought and development.

Clearly medical and dental students could be taught and have time set aside in the syllabus for the study of descriptive ethics and moral philosophy, but the value of doing this beyond the minimum necessary to engage in the practice of normative ethics is questionable. After all medical and dental students are being trained to become Health Professionals and not moral philosophers or moral sociologists. What is needed is the ability for medical and dental students to be

competent practitioners rather than moral philosophers or moral anthropologists. But part and parcel of being a competent practitioner is the ability to justify and give cogent reasons for ones practice. The ability to do this is a skill that can be, not to much taught, as enhanced. What our present students need as doctors and dentists of tomorrow is the skill of sound ethical reasoning, judgement and deliberation.

Ethical reasoning is, first and foremost, a skill that can be developed and encouraged rather than taught formally. Central to its enhancement is creating the space in which the student is encouraged to reflect on practice and justify outcomes within a moral framework. This is not something that can happen with the student in the role of a passive participant as is the case in most lectures, the reading of books and the watching of videos. Central to the learning process is the opportunity to express ones opinion, to be able to defend that opinion and to modify ones opinion in light of factors that the student may have overlooked or failed to have considered in first instance.

Thus the ideal way of enhancing these skills is not in the lecture hall, but rather in small tutorial groups or individual firms. In this context it is possible for the students to be heard and to be encouraged in their thinking and critical reflection. Material is readily to hand. The tutor can provide case studies tailored to bring out a particular aspect of ethical concern, such as the importance of confidentiality. Better still is the use of actual experience that students gain from their firms as this is more memorable. In other words as well as 'collecting' interesting cases of diseases and learning about their management, students should also be aware of the ethical dimension that is omnipresent in every aspect in the delivery of health care.

The need for ethics within the School Curriculum is evident. Here at UMDS we have completed the exercise of defining what should be in the Core Curriculum and await the decision of the Medical Education Committee. Through the Ethics Steering Group it has been proposed to have a short foundation course that takes place early within the curriculum. This course equips the student with the appropriate language and tools with which to participate within ethical decision making. During the clinical phase of training, students are to have dedicated time in which to work on ethical issues that have arisen within the clinical context. It is important for this to take place in clinical time as ethics is integral to clinical practice. Rather than 'bolt-on' our ethics, it will be delivered as 'drip-feed'. In the same way that it is recognised that time needs to be set aside for students to

develop their communication skills, so too does time for critical ethical reflection need to built in.

Finally, comes the tricky question of assessment. How does the School assess the competence of its students in regards to ethics? How do we assess whether the School is producing 'Good Doctors for Tomorrow'? This is in itself a moral question. Means of assessment are being modified and updated. In the past there might have been an ethics question in Finals and possible ethical issues might have been raised in a viva. This continues to be the case, but in addition there are ethical and legal issues being examined through the use of OSCEs (Objective Structured Clinical Examinations). Further work is being done at the Education Development Unit [at UMDS] to study critically whether the methods of assessment currently employed actually do the task they purport to do. In the assessment of ethics in particular, we are looking at the idea of asking students to comment on the ethical and legal implications of incomplete case studies. This allows the student to demonstrate that depending on the particular situation, which the student needs to state, then certain outcomes may or may not be justifiable. Why this type of assessment is to be preferred as it demonstrates to the examiner the capacity of the student to recognise the scope of the situation and the student's ability to think.

No method of assessment is going to be without fault for whichever method is used it will favour those who have a certain flair in, for example, short term memory or in expressing themselves well on paper. The Good Doctor of Tomorrow will need to have skills in ethical reasoning and awareness. It is the duty of our School to make sure that they do.

Peter Haughton

The author is the part time adviser in Medical Ethics and Law. He is also a part time Parish Priest in the Church of England. Before he was appointed adviser at UMDS he was a Higher Education Chaplain working within the Medical Schools in London University.

Guy's Hospital Gazette

English Pewter Goblets, Engraved with the Guy's Crest, available only from the *Gazette*, individually boxed. **Price £22+£1 p&p**

ORDER FORM

Name .....

Address .....

Tel: .....

Please send me . . . . . Guy's Goblets at £22+£1 p&p

I enclose a remittance of £.....

To: The Manager, Guy's Gazette Office,
Guy's Hospital, London SE1 9RT
Tel: 0171 955 5000 ext 5413

Personal Callers Welcome

Office hours: Monday to Friday. 1—5 p.m.

An Interview with Professor Williams

New Clincal Dean for UMDS

Professor Gwyn Williams is a Consultant Nephrologist at Guy's hospital. He also holds the post of Chairman of Medicine and is soon to take over as Clinical Dean in August. He has been a Consultant at Guy's since 1974 and in his time here has done much research and teaching as well as examining undergraduates.

Could you tell us a little about your medical school days?

My medical school days were spent in Cardiff at the Welsh National School of Medicine and they were very enjoyable - I had something which I think has to be injected into every medical students' career, that being fun. Eventhough I liked studying, I spent a lot of time playing sport and I had many outside interests like music and photography. Unfortunately, I suffered a major shoulder injury playing rugby half way through my medical student days which really affected me and put an end to playing sports.

I particularly remember my elective which was spent in Israel and at that time it wasn't on the holiday map - it was unspoilt territory. It was a wonderful experience, I saw a lot of medicine, a lot of Israel and a lot of the people.

After finishing my medical school days at Cardiff, I did a few jobs there and then I moved to Oxford, then to the Hammersmith and finally to Guys'. So that's my whole medical career just down the A40.

Did you do anything outrageous at medical school?

Well, the usual things like getting a car and pushing it through the Royal Infirmary and leaving it in the main hall to be seen by all the consultants and removed with great difficulty by the porters. I remember once as the site of the hospital was on the main road, we made a huge 40 yard banner saying simply 'For

Sale' and hung it between two flag poles at the top of the hospital. But nowadays, that wouldn't look so amusing, probably just appropriate. It was certainly a climbing feat of some magnitude which I wouldn't like to repeat.

Why did you choose nephrology? Was there any specific event in your career that guided you towards it?

I can't remember any specific event as such but I qualified at a time where the management of acute renal failure by dialysis was just being established. This type of treatment was still on the learning curve and I found the clinical problems associated with looking after patients with acute renal failure very interesting and challenging. I enjoyed the pathophysiology of kidney failure. The patients are very challenging to look after as they often have multi-system illness and they need a whole team of people to care for them. Not just the renal team gets involved; often the vascular surgeons, orthopaedic surgeons, microbiologists, ITU, etc are needed. The treatment of chronic renal failure followed on from the treatment of acute and this in itself became a very interesting field and after these came transplantation. Infact, part of the reason that transplantation became successful was that dialysis allowed patients to wait safely for transplant which is still a problem for patients requiring heart, lung, and liver transplants. There is no equivalent of dialysis for these patients so there is a rush to get the organ and we don't have that pressure with kidneys.

When and where did you become a Consultant and Professor?

I became a Consultant at Guy's in 1974 and then a Professor in 1990 by doing the usual mixture of research, teaching, and clinical work in medicine and the speciality of nephrology.

Why did you choose Guy's?

I chose Guy's because it had then, as it still does now, one of the best renal units in the world. I also think it was the hospitals' reputation as a whole for having excellent clinical care. London wasn't a consideration, it didn't have to be London, I was always intent on working in a centre of excellence.

What does your present job at Guy's involve?

Well, it's looking after patients with renal failure before and during their time for dialysis and transplantation, and also patients with nephritis, stones, hypertension - the whole range of clinical nephrology. We work separately as far as teams go from the paediatric nephrologists but we do collaborate considerably in the clinical meetings we have and that means we can bounce problems off each other. It is definitely very useful as we get young patients who are technically adults but have the problems that they are somewhat more familiar with and vice versa. So we share our expertise on a weekly basis.

When did you become Chairman of Medicine and what does that involve?

I became chairman of medicine in 1989. The division of medicine is a medical school administrative division. In the same way that there are the basic science divisions of Anatomy, Physiology and so on there are clinical divisions as well, Medicine being the largest. As Chairman you are responsible for the personnel, finance and administration within the division and teaching of your discipline to undergraduates. You also have to ensure that there are proper facilities for research and that research is done.

What are the problems you foresee for yourself when you take over as Clinical Dean in august?

Well, first I will have to discontinue my chairmanship of division. As problems go there are none, just challenges. The first challenge is to ensure that our medical students enjoy their clinical teaching and that we produce between us at the end of their course a graduate who has enjoyed their clinical course and who is looking forward to practising medicine. Now those may sound like platitudes but we are faced with difficulties as shown by the fact that not all students enjoy their clinical years as much as I think they should. Perhaps the most worrying feature of British medical life at the moment is the large drop out rate of young doctors from medicine at about five years postgraduating. Obviously there are issues that come out in the post-graduate phase that are not relevant to a Clinical Dean but I think when we are launching young doctors at graduation onto the next five to ten years it is our job to ensure they are in 'tip top' condition to do so. That is, they don't

start their new careers being jaded but having thoroughly enjoyed their clinical training period.

The other main challenge for the Clinical Dean is to make undergraduate teaching relevant to the medicine that is being practised now and the medicine that we expect to be practising in the next five to ten years. The other issues I would like to address as Clinical Dean are to ensure that our research program in the clinical faculty is maintained at least at its present level and perhaps even increase in quality and amount. Of course the ultimate challenge faced here at UMDS at the moment is to ensure our smooth and fruitful merger with King's College.

Another important challenge is the pastoral care of the clinical medical students. Due to the large size of the years it makes it very difficult and also during their three clinical years many students spend a good proportion of their time away from the Guy's or St Thomas' campus sites.

As an external examiner, how do you feel students from UMDS compare with those from other medical schools?

Each medical school has a very different flavour, different types of people tend to go to different medical schools. UMDS students are definitely above average. There isn't much difference in knowledge but it is the style that varies. Wrapped around each school is a very different style of learning and the students here have a 'buzz' which makes them fun to teach (and examine!).

Do you think that students should study medicine as a post-graduate subject as they do in America?

One of the difficulties with that is the finance and a problem that the American medical community have to deal is the debtor graduate. They often end up in heavy debt due to the length of the course and the fees which in turn goes onto govern the way in which they have to practice afterwards. One of the main problems this engenders into American medicine is the fact that people have to earn to pay off their debts which reduces their inclination to do research. If that is applied here and young doctors felt that they had to get on and forego research for financial reasons, their input into medicine would be reduced.

How did you become so deeply involved in the Staff Round?

I became involved in the Staff Round when my predecessor, Professor Maurice Lessof, just asked me to take it over. I originally agreed just for a change but I have been doing it ever since. I will shortly relinquish it however as becoming Clinical Dean I won't be able to commit myself to regular 1 o'clock meetings on one campus.

Are you going to be involved in examining the medical students at finals?

You bet! I'm not going to drop any teaching commitments and I will certainly be in on the exams.

Finally do you miss Wales?

Enormously, yes I do. We go back there for a holiday every year.

Kate Mundray

Guy's Hospital Gazette

English Pewter 1 pt Tankards, Engraved with the Guy's Crest, available only from the *Gazette*, individually boxed.

Price £22+£1p&p

ORDER FORM

Name .....

Address .....

Tel: .....

Please send me . . . . . Guy's Tankards at £22+£1 p&p

I enclose a remittance of £.....

To: The Manager, Guy's Gazette Office,
Guy's Hospital, London SE1 9RT
Tel: 0171 955 5000 ext 5413
Personal Callers Welcome

Office hours: Monday to Friday 1–5 p.m.

Astley Cooper and the first ligation of the Aorta

Professor Harold Ellis depicts a great Guy's man!

You may disagree with me, but in my opinion Astley Paston Cooper was the greatest clinician - and certainly the greatest surgeon - produced by the United Hospitals of Guy's and St Thomas'.

Cooper was one of the fathers of modern vascular surgery. He pioneered ligation of the carotid artery for aneurysm, he devised the extraperitoneal approach to the external iliac artery for femoral aneurysm and, although the cases ended fatally, he was the first surgeon to ligate the abdominal aorta. This operation was performed in 1817 and it remained for Rudolph Matas, over a century later, to report the first successful ligation of the aorta for aneurysm in 1925.

Astley Cooper was born in 1768, the son of a Norfolk country clergyman. At the age of 16 he became articled to his uncle, William Cooper, who was the senior surgeon at Guy's Hospital. However, Astley lived with Henry Cline, surgeon at St Thomas'. In those days the two hospitals were opposite each other across St Thomas' Street and were known as the United Hospitals. Medical students were attached to both institutions, their lectures in medicine being at Guy's and those in the surgery and anatomy at St Thomas'.

Cline encouraged young Cooper to attend the lectures of John Hunter and, six months after arriving in London, Astley transferred his apprenticeship to Cline. He now began his lifetime interest in anatomy. While still a pupil, he was appointed, first, demonstrator in anatomy and then, at the age of 23, helped Cline with his course of lectures.

Cooper was appointed to the surgical staff at Guy's hospital in 1800 and there he spent the rest of his professional life.

He must have been one of the hardest working surgeons in history. At the height of his fame he would rise every morning by six, often by five and sometimes as early as four. He would go straight to his dissecting room, which was a shed in

his own home, and there he would experiment until breakfast. From then until 1 o'clock he gave free consultations at his home. He then went to Guy's Hospital, where crowds of students would attend his ward rounds, clinical lectures and operating sessions. Visits to private patients and operations in their homes would follow. He would be home by seven, take a hurried meal, and then out again to see more patients or to lecture, rarely arriving home before midnight. He used to say that a day spent without dissection was a day wasted.

'He used to say that a day spent without dissection was a day wasted.'

Cooper's contributions to surgery were considerable. In addition to his work on arterial ligation, he was one of the first surgeons to carry out a successful disarticulation of the hip. This procedure was performed in 1824 on a soldier wounded at the Battle of Waterloo, with chronic osteomyelitis of the femur following an above knee amputation. His monograph on hernia, published in 1804, gives an account of the anatomy of the groin which can be read with profit to this day. It contains the first description of the fascia transversalis, which he so named. His other monographs were 'Fractures and Dislocations' (1822), 'Illustrations of Diseases of the Breast' (1829), 'Observations on the Structure and Diseases of the Testis' (1830), 'The anatomy of the Thymus Gland' (1832) and 'On the Anatomy of the Breast' (1840). The guiding principle in Cooper's teaching is stated in the preface to his treatise on Hernia, in which he states:-

'I have almost uniformly in this work avoided quoting the opinion of authors on this part of surgery...I have therefore related no case, and given no remark to the truth of which I cannot vouch'.

'I have almost uniformly in this work avoided quoting the opinion of authors on this part of surgery...I have therefore related no case, and given no remark to the truth of which I cannot vouch'.

At the age of 57, Astley Cooper resigned as Senior Surgeon to Guy's Hospital but continued with his private practice and his dissections. In 1827 he was elected President of the Royal College of Surgeons and in 1836 was

elected for a second term in office. He died in 1841, at the age of 72, from what was probably hypertensive cardiac failure.

'While still a student, he investigated the collateral circulation in the dog following femoral and brachial artery ligation.'

To return now to Cooper's contributions to vascular surgery. He was not simply a bold surgeon, who ligated most of the majors arteries of the body, but his work was based on careful observation and experimental studies. While still a student, he investigated the collateral circulation in the dog following femoral and brachial artery ligation. He made extensive studies on ligation of the carotid and vertebral arteries and had one dog that actually survived serial ligation of all four of these vessels. In 1811, he reported successful collateral circulation (see below). One of these specimens still survives in the Gordon Museum at Guy's and is well worth a close inspection.

When, in 1817, a patient presented at Guy's Hospital with a rapidly expanding iliac aneurysm, which was obviously on the point of rupture, Cooper had the opportunity to put his experimental observations to the test. At this point he went to the post mortem room and attempted to expose the aorta through a lateral retroperitoneal incision, found this to be 'utterly impracticable' and practised the trans-abdominial approach. His operation of aortic ligation had therefore been completely studied, both from its physiological and anatomical aspects.

'A patient presented at Guy's Hospital with a rapidly expanding iliac aneurysm, which was obviously on the point of rupture, Cooper had the opportunity to put his experimental observations to the test.'

As the following case report describes, the collateral circulation was indeed sufficient on the normal side, but on the side of the aneurysm, where collateral channels were no doubt disrupted and thrombosed, the leg became ischaemic and the patient died.

The following is a somewhat shortened version of Cooper's description of the operation:-

'Charles Hutson, a porter, age 38, was admitted into Guy's Hospital, on the 9th April 1817, for an aneurysm in the left groin, situated partly above and partly below Poupart's ligament. The swelling was very much diffused, and pressure upon it gave considerable pain. On the third day after he had been in the Hospital, the swelling increased to double its former size, and extended from three to four inches above Poupart's ligament to an equal distance below it, and was of great magnitude. Just below the anterior and superior spinous process of the ilium, a distant fluctuation could be felt in the aneurysmal sac, so that the blood had not evidently yet coagulated; and the peritoneum was carried far from the lower part of the abdomen, in such a manner as to reach the common iliac artery, and to render an operation averse to perform an operation, and determined to wait and see if any efforts would be towards a spontaneous care.

'He was occasionally bled, kept perfectly quiet, and pressure was applied on the tumour.'

He was occasionally bled, kept perfectly quiet, and pressure was applied on the tumour. June 19th, a slough was observed on the exterior part of the swelling below Poupart's ligament, which, in part, separated on the 20th, and he had some bleeding from the sac, but it was easily stopped by a compress of lint, confined on the part by adhesive plaster. On the 22nd, after some slight exertion, he bled again, but not profusely. 24th, the bleeding again recurred, but stopped spontaneously. 25th, about half-past two o'clock, in consequence of a sudden mental agitation, bled profusely, and became so much exhausted that his faeces passed off involuntarily; but Mr Key, then my apprentice, succeeded in preventing immediate dissolution by pressure. At nine o'clock the same evening I saw him again, and found him so reduced in state, that he could not survive another haemorrhage, which he was every moment threatened. Yet still anxious to avoid opening the abdomen, to

'...in consequence of a sudden mental agitation, bled profusely, and became so much exhausted that his faeces passed off involuntarily.'

secure the aorta near to its bifurcation, I made an incision into the aneurysmal sac, above Poupart's ligament, to ascertain if it were practicable to pass a ligature around the artery from thence. On introducing my finger, I found that the artery entered the sac above and quitted it below, without there being an intervening portion of vessel; I therefore, was obliged to abandon that mode of operation; and as the only chance which remained of preventing his immediate dissolution, by haemorrhage, was by tying the aorta, I was determined on doing it. The operation was performed as follows:

'as the only chance which remained of preventing his immediate dissolution, by haemorrhage, was by tying the aorta, I was determined on doing it.'

The patient's shoulders were slightly elevated by pillows, in order to relax, as much as possible, the abdominal muscles. I then made an incision, three inches long, into the linea alba, giving it a slight curve, to avoid the umbilicus: one inch and a half was above, and the remainder below the naval. Having divided the linea alba, I made a small aperture into the peritoneum, and introduced my finger into the abdomen; and then with a probe-pointed bistoury enlarged the opening into the peritoneum to nearly the same extent as that of the external wound. During the progress of the operation, only one small convolution of intestine projected beyond the wound.

Having made a sufficient opening to admit my finger into the abdomen, I passed it between the intestines to the spine, and felt the aorta greatly enlarged, and beating with excessive force. By means of my finger nail, I scratched through the peritoneum on the left side of the aorta, and then gradually passed my finger

'By means of my finger nail, I scratched through the peritoneum on the left side of the aorta, and then gradually passed my finger between the aorta and spine, and again penetrated the peritoneum, on the right side of the aorta.'

between the aorta and spine, and again penetrated the peritoneum, on the right side of the aorta.

I had now my finger under the artery, and by its side I conveyed the blunt aneurysmal needle, armed with a single ligature behind it; and Mr Key drew the ligature from the eye of the needle to the external wound, when the needle was withdrawn.

The next circumstance, which required considerable care, was the exclusion of the intestine from the ligature, the ends of which were brought together at the wound, and the finger was carried down between them, so as to remove every portion of the intestine from between the threads: the ligature was then tied, and its ends were left hanging out of the wound.

'He gradually sunk, and died at eighteen minutes after one o'clock, having survived the operation forty hours.'

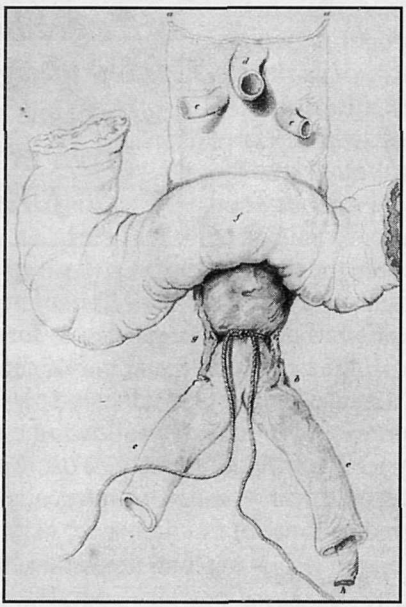
The omentum was drawn behind the opening as far as the ligature would admit, so as to facilitate adhesion; and the edges of the wound were brought together by means of a quilled suture and adhesive plaster.

He remained very comfortable until the following evening, when he vomited, and his faeces passed off involuntarily. 27th, Seven o'clock am, had passed a restless night, and had vomited at intervals; pulse 104, weak and small; pain in head; great anxiety of countenance; very restless, and his urine dribbled from him. He gradually sunk, and died at eighteen minutes after one o'clock, having survived the operation forty hours.

Dissection

No peritoneal inflammation, but at the edges of the wound, which were glued together by adhesive matter, except at the part at which the ligature protruded. The thread had been passed around the aorta, about three quarters of an inch above its bifurcation, and rather more than an inch below the part at which the duodenum crosses the artery; it had not included any portion of omentum, or intestine. The aneurysmal sac, which was of a most enormous size, reached from the common iliac artery to below Poupart's ligament, and extended to the outer part of the thigh. The artery was deficient from the upper to the lower part of the sac, which was filled with an immense quantity of coagulum.'

The specimen can be seen today, carefully preserved, in the Professional Surgical Unit at St. Thomas'.



'Contemporary illustration of the
post-mortem specimen of the ligated aorta'

References

Cooper, A. (1825) 'Lectures of Sir Astley Cooper Bart. Volume 2' London, Thomas and George Underwood 69-72.

Ellis, H (1985) 'Surgical Case Notes from the Past' London, Royal Society of Medicine Press.

Professor Harold Ellis,
Department of Anatomy, UMDS

Now available, in limited stock, full colour prints depicting Thomas Guy discussing the plans for his hospital with Dr Mead, the physician, and Mr Stear, the architect who designed the East Wing.

The cards are available blank or with Christmas Greetings.

Price: 10 for £6.00 + £1.00 p & pkg
Size: 218 × 163 mm

When ordering, please indicate choice of message

Cheques may be made payable to Guy's Hospital Gazette

The Guy's Hospital Staff Round: Case Reports

A destructive headache - hemicranial pain in the polyglandular autoimmune syndrome.

A 46 year old caucasian woman presented to her local hospital with a 2 month history of a persistent right sided headache, an intermittent right earache with discharge and associated episodes of vomiting. This had led to labile control of her diabetes mellitus.

In the past she had been diagnosed with insulin dependent diabetes mellitus at the age of 23 years. In the same year Addison's disease and hypothyroidism were diagnosed, and she had suffered with vitiligo. The associations were in keeping with a polyglandular autoimmune syndrome although auto-antibody screens for islet cell, adrenal, ovarian, gastric parietal and other cells types were negative. More recently she had been troubled by recurrent sinusitis since 1993 requiring multiple washouts and mucosal debridement of the maxillary sinuses and surgical suction of the right ethmoid sinus. A computerized tomograph (CT) of the sinuses earlier in the year had revealed sinus mucosal thickening.

On day 2 of her hospital admission she suffered a cardiorespiratory arrest following a hypoglycaemia seizure. Following successful resuscitation and 24 hours of mechanical ventilation, she was extubated and transferred to the general ward. At this time she was found to have a left hemiparesis due to a right parietal haemorrhagic infarct confirmed by CT, a right lateral rectus palsy and right Horner's syndrome (Fig 1). In view of the presenting clinical features and subsequent signs, skull base pathology was suspected with concern of a mucormycosis, inflammatory or meningitic process. Magnetic resonance imaging(MRI) of the head confirmed the right parietal infarct and also demonstrated meningeal enhancement, opacified ethmoid and sphenoid sinuses and significantly, right paranasal and skull base soft tissue swelling (Fig 2).

She remained unwell with a reduced conscious level and poor endocrine control. She was transferred to Guy's Hospital 10 days after admission for further

management of suspected mucomycosis. Her symptoms of intermittent right, throbbing hemicranial pain, right sided otalgia and vomiting were unchanged. The left hemiparesis had recovered as had the right abducens nerve palsy. However the right Horner's syndrome persisted. She had been commenced on oral co-amoxiclav and ciprofloxacin. In light of her slight improvement mucormycosis was thought unlikely, and mucor serology was indeed negative. A lumbar puncture revealed only a mild csf protein rise (0.6 g/L). She had a normochromic, normocytic anaemia (Hb 10.0g/dL), white cell count 8.3 x 10^9/L, erythrocyte sedimentation rate(ESR) 43mm and c-reactive protein(CRP) 33mg/L. Ear swabs from the right were repeatedly negative (while on antibiotics).

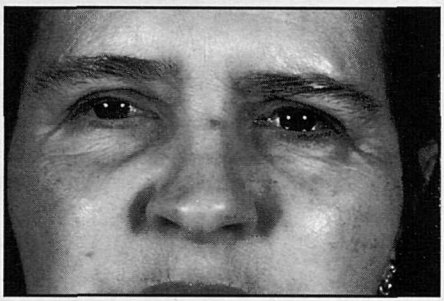


Fig 1. Right sided Horner's Syndrome. Note the miosis and reduced palpebral fissure size due to partial ptosis.

Auroscopy revealed a right middle ear effusion that was drained and a grommet inserted. The effusion was microbiologically sterile. Nasendoscopy showed inflammed right sided nasal mucosa. While on the ward she developed a prolonged period of reduced consciousness, despite normal blood glucose and diurnal cortisol levels. The possibility of venous sinus thrombosis was raised and a magnetic resonance angiogram(MRA) was performed; this excluded venous thrombosis (Fig 3) but demonstrated a complete occlusion of the right internal carotid artery (Fig 4) with enhancing tissue adjacent to the right cavernous sinus.

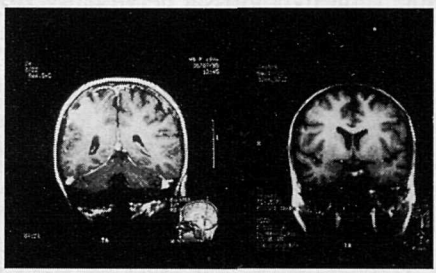


Fig 2. Coronal MRI sections demonstarting a right parietal infarct and meningeal enhancement (first scan). An unenhanced scan (second scan) shows soft tissue swelling near the right skull base.

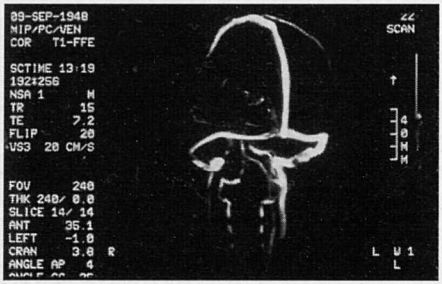


Fig 3. Venous phase MR angiography demonstrating normal venous sinuses.

Progress

Her conscious level and general condition improved on oral co-amoxiclav and ciprofloxacin. Carbamazepine was added for the headache and she was discharged home 6 weeks after admission.Four weeks later she was readmitted with the same symptoms of a right sided headache extending from the orbital margin back to the occiput, an ear discharge, vomiting and labile endocrine control. She had developed a visible right hypoglossal nerve palsy (Fig 5) and right conductive deafness. The ESR was 76mm, CRP 71mg/L and CT of the skull excluded an intracerebral abscess but showed opacification of the tip of the right mastoid bone (Fig 6). Surgical exploration of the mastoid revealed friable, abnormal textured bone.

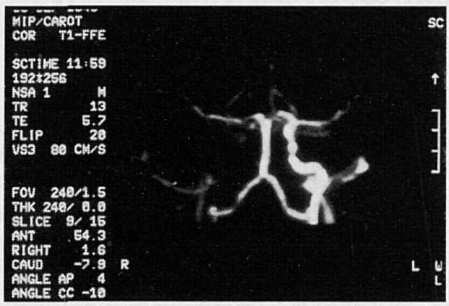


Fig 4. MRA scan demonstrating total occlusion of the right internal carotid artery.

The clinical picture was one of a persistent severe right headache, progressive lower cranial nerve palsies and a right internal carotid artery occlusion in chronic middle ear/sinus disease. Investigations to date had shown abnormal skull base imaging, abnormal bone surgically and persisting inflammatory markers despite 6 weeks of oral antibiotics. The possibility of osteomyelitis of the skull base secondary to chronic pseudomonal middle ear/sinus disease was considered, although no direct microbiological evidence had been forthcoming.

A technetium(Tc^{99})-MDP(methylene diphosphonate) bone scan and spect imaging demonstrated increased uptake in the right skull base consistent with osteomyelitis of the petrous temporal bone (Fig 7). She was commenced on intravenous gentamicin with symptomatic improvement initially. However con-

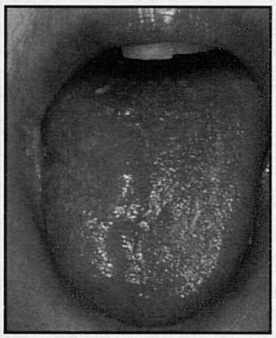


Fig 5. 12th cranial nerve palsy (right). Note the muscle wasting and deviation of teh tongue to the side of the lesion.

cerns regarding potential ototoxicity, and a previous documented allergic reaction to ceftazidime necessitated a change to clindamycin and ciprofloxacin. This was complicated by antibiotic induced diarrhoea (stool sample positive for clostridium difficile toxin), and she was commenced on intravenous(iv) imipenem through a Hickman line.

The combination of iv imipenem and oral ciprofloxacin continued for 6 weeks as an out-patient within which time there was resolution of her hemicranial symptoms, stabilization of her endocrine control, improvement in the inflammatory markers (ESR 21mm, CRP 7mg/L) and a (Tc^{99}) white cell scan showed resolution of bone uptake (although there was increased uptake in the right maxillary sinus consistent with the previous chronic sinusitis).

Two weeks on, the Hickman line became infected and was removed, at which time antibiotics were discontinued. Soon afterwards she presented again with right facial pain (but no headache) and ESR 128mm,CRP 35mg/L. A nasal biopsy grew 2 pseudomonal species and histology did not demonstrate granulomatous disease nor features of wegener's granulomatosis. Indwelling intravenous access was resited and imipenem recommenced together with oral ciprofloxacin.

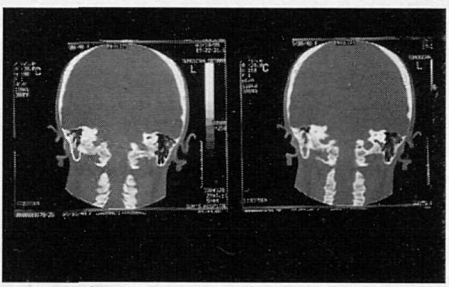


Fig 6. CT scans of the skull bones demonstrating opacification in the right mastoid.

She required a subsequent admission for a pelvic fracture secondary to a fall at herlocal hospital;this followed a generalized seizure when her endocrine state was once again unstable.An electroencephalograph demonstrated a diffusely abnormal pattern in keeping with a metabolic encephalopathy.With conservative management she improved and was discharged home independently mobile.

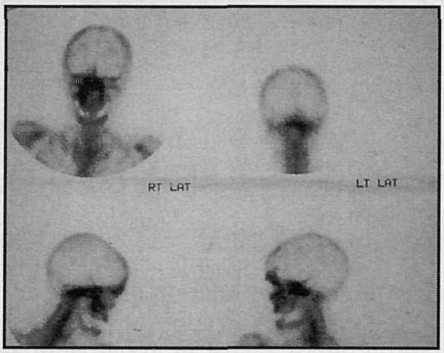


Fig 7. Radionucleotide MDP bone scan showing increased activity in the region of teh paranasal sinuses and right temporal bone.

Follow-up

Further Tc^{99} white cell scans have shown resolution of bone uptake but persisting right maxillary sinus uptake (Fig 8) 6 months after commencing combined antipseudomonal therapy. The imipenem was stopped after 4 months but ciprofloxacin has continued with no symptoms and biochemical stability;ESR 20mm and CRP mg/L.

Discussion

The case described represents a potentially fatal complication of chronic ear infections but a less well documented complication of chronic sinusitis, in a predisposed patient with poorly controlled insulin dependent diabetes mellitus. Indeed our patient had features in keeping with type II polyglandular autoimmune syndrome (but without auto-antibody evidence), which made her endocrine control more troublesome in the presence of a severe infection.

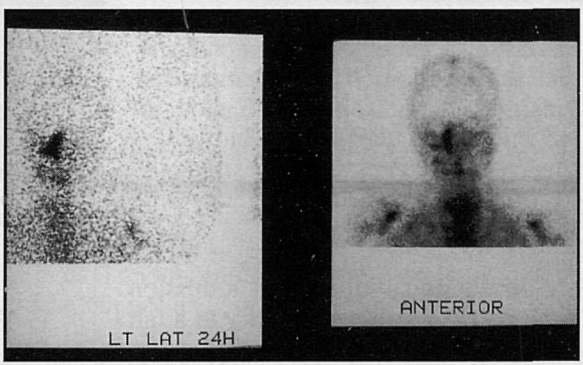


Fig 8. Tc^{99} white cell scan showing resolution of the previous tekporal bone uptake but persisting activity in the region of the right maxillary sinus.

The background of chronic sinusitis pointed to that as the source of her presenting symptoms. However, the progressive lower cranial nerve palsies and right Horner's syndrome suggested more extensive skull base pathology. In fact, MRI confirmed the soft tissue swelling and MRA showed right internal carotid artery occlusion, to account for the Horner's syndrome and right parietal infarct. The apparent failure of treatment with initial oral antibiotics, the CT finding of opacification of the mastoid cavity and abnormal bone texture strengthened the likelihood of osteomyelitis confirmed by radioisotope scanning. Prolonged intravenous antipseudomonal treatment led to eventual clinical and biochemical improvement consistent with the serial radionuclide scan changes.

Pseudomonal osteomyelitis of the skull base in an elderly diabetic man was first described by Meltzer and Keleman in 1959[1]. The term malignant otitis externa (MEO) was coined in 1968 to describe a bacterial infection of the external auditory meatus (EAM) spreading to the soft tissue or bone and associated with cranial neuropathies[2,3]. A retrospective analysis revealed a very strong association of MEO with diabetes mellitus and the isolated organism was invariably pseudomonas aeruginosa. Invasive external otitis (IEO)[4] and necrotizing external otitis (NEO)[5] describe the same condition as MEO and 3 of 5 criteria are sought for a diagnosis:

1. persistent external otitis
2. granulation tissue in the EAM
3. diabetes mellitus or an immunocompromised state
4. osteomyelitis of the skull base (by CT, MRI or radionuclide imaging)
5. cranial nerve involvement

Our patient had no evidence of external ear disease but rather a chronic pseudomonal sinusitis, which has rarely been reported as progressing to the complications described.The pathogenesis of MEO in diabetes mellitus is thought to be a microangiopathy in the skin of the EAM ; this allows spread of infection into the soft tissues.A similar mechanism could conceivably account for spread from chronic bacterial sinus disease. Clinical features in osteomyelitis of the skull base[6] include:

1. a characteristic unilateral unremmitting headache,
2. conductive hearing loss due to a middle ear effusion,
3. progressive cranial neuropathies- cVI (lateral rectus palsy)

c XI,X (hoarse voice,dysphagia or aspiration)
c XII (tongue deviation)

4. venous sinus thrombosis,
5. intracerebral abscesses,
6. meningitis, and a previously documented case of internal carotid artery infiltration.

The investigation of suspected skull base osteomyelitis requires good imaging techniques to confirm clinical suspicions at the earliest oppurtunity. High resolution CT scans pick up sclerotic and destructive changes in the bone as well as soft tissue thickening. MRI scans are probably superior to CT at detecting soft tissue changes in this setting[7] but the changes persist after clinical resolution and are therefore less useful in monitoring progress than CT[8]. Technetium labelled bone scans are a sensitive indicator of early bone involvement even before CT changes. However, they are non specific with limited anatomical detail and remain positive after clinical resolution.

Thus Tc^{99}bone scans have been recommended for early diagnosis but not for monitoring disease regression[9] where Gallium[67] citrate labelled bone scans correlate better with clinical resolution. During the investigation of the case descibed, an initial standard bone scan demonstated localized uptake in the area of CT changes, consistent with an infective process within the petrous temporal bone. Subsequent serial radionuclide scans were performed using Tc^{99} labelled white cells; these scans showed changes in keeping with resolution of the bone infection but persisting asymptomatic chronic sinus inflammation. In our experience, Tc^{99} white cell scans provided useful disease monitoring function and are likely to be effective in the early diagnosis of skull base osteomyelitis.

The treatment and prognosis of skull base osteomyelitis have improved since the introduction of effective antipseudomonal antibiotics in the 1970's, prior to which radical surgical resection was the standard treatment with 50% disease-associated mortality. A number of different antibiotic regimes have been utilized in retrospective and prospective trials. In general, a combination of 2 antipseudomonal agents for a minimum of 4 weeks is recommended, but decisions on the duration of treatment should be based on evidence of clinical, biochemical and radionuclide improvement.

Frequently, prolonged or repeated courses of an aminoglycoside and a semisynthetic penicillin have been required [3,4]. Indeed, in a prospective study of 15 patients with chronic pseudomonal osteomyelitis (non cranial), 2 intravenous

antipseudomonal agents were required for over 4 months to achieve a 73% clinical cure rate and 93% bacteriological cure rate[10]. Oral ciprofloxacin alone was successful in maintaining disease remission after 18 months[11] when used in doses of 1.5 grams/day for up to 15 weeks.In this case the use of combination therapy initially involving an intravenous antipseudomonal agent and oral agent for at least 6 weeks followed by continuation of high dose oral ciprofloxacin, proved successful.

This case documents the protracted clinical course and subsequent diagnostic process of a patient with an unstable polyendocrinopathy and chronic sinus disease complicated by a near fatal skull base infection.Osteomyelitis of the skull base is a potentially fatal complication in predisposed individuals with chronic sinus or ear disease. A knowledge of the clinical features, a high index of suspicion, early diagnostic tests and prolonged antibiotic regimes based on effective monitoring of disease resolution will reduce serious consequences.

References

1. Meltzer PE, Keleman G. Pyocyaneous osteomyelitis of the temporal bone, mandible and zygoma. Laryngoscope 1959;69:1300

2. Chandler JR. Malignant external otitis. Laryngoscope 1968;78:1257-1294

3. Chandler JR, Grobman L, Quencer R et al. Osteomyelitis of the base of the skull. Laryngoscope 1986;96:245-251

4. Doroghazi RM, Nadol JB, Hyslop NE et al. Invasive external otitis. American Journal of Medicine 1981;71:603-614

5. Blake GB, Gianoli GJ.. Necrotizing external otitis. J La Med Soc 1993;145(2):43-45

6. Dolan RW, Chowdhury K. Diagnosis and treatment of intracranial complications of paranasal sinus infections. J Oral Maxillofac Surg 1995;53:1080-1087

7. Gherini SG, Brackmann DE, Bradley WG. Magnetic resonance imaging and computerized tomography in malignant external otitis. Laryngoscope 1986;96:542-548

8. Murray ME, Britton J. Osteomyelitis of the skull base: The role of high resolution CT in diagnosis. Clinical Radiology 1994;49:408-411

9. Parisier SC, Lucente FE, Hirschman SZ et al. Nuclear scanning in necrotizing progressive malignant external otitis. Laryngoscope 1982;92:1016-1020

10. Lucht RF, Fresard A, Berthelot P et al. Prolonged treatment of chronic pseudomonas aeruginosa osteomyelitis with a combination of 2 effective antibiotics. Infection 1994;22(4):48-52

11. Levenson MJ, Parisier SC, Dolitsky J, Bindra G. Ciprofloxacin: Drug of choice in the treatment of malignant external otitis (MEO). Laryngoscope 1991;101:821-824

Suveer Singh, Registrar in Respiratory/General medicine
John Rees, Senior Lecturer in medicine/Consultant Physician

Guy's Hospital - 250 years

Have you ever wanted to know more about the history of Guy's? What was student life like in the nineteenth century medical school? What happened in the Resident's Plays of the Forties and Fifties? How about nursing, midwifery, the Wills Library? Or the early days of X-rays?

This 240 page, illustrated paperback gives a history of the achievements in every field of Guy's life for the past 250 years, and is available for only £3.95, including postage and packing, from the Gazette office. The book makes an ideal gift, and only a limited number are available.

Please send cheques or postal orders, made payable to Guy's Gazette, to Guy's Hospital - 250 Years, Guy's Gazette, Boland House, London SE1 9RT

"UNDERGRADUATE MEDICAL STUDENT?"
"UNCERTAIN ABOUT YOUR FUTURE?"
"LOOKING FOR 10 YEARS SECURITY?"

GOOD ENOUGH FOR THE ARMY?

If you are within 3 years (or less) of graduation you may wish to consider Army Sponsorship. The Royal Army Medical Corps (RAMC) offers cadetships to suitable candidates. Medical school fees are paid by the Army, cadets receive an annual salary in excess of £10,000 and there is no military commitment during the undergraduate years - unless you want us to arrange your electives and attachments.

If you are interested in being a doctor in the Army for 6 years following full GMC registration we shall provide financial help during your medical studies. To find out more and learn about the RAMC, attend one of our monthly familiarisation visits.

Why not let us help plan your future?

ARMY
OFFICER

BE THE BEST

For further information, including details of the RAMC, the cadetship scheme and rates of pay, write to Col (Retd) AP Willman, Officer Recruiting, Regimental HQ RAMC, Keogh Barracks, Ash Vale, Aldershot, Hants GU12 5RQ. An applicant must be a UK citizen, pass a medical and successfully appear before a selection (interview) board before a cadetship is awarded.

NAME _____

ADDRESS _____

_____

_____ POSTCODE _____

TEL _____ AGE _____

Immunobiology - The Immune System in Health & Disease

This is a well structured, well written general immunology textbook. The authors have targeted it for use as an introductory text for medical students, advanced undergraduate biology students and graduates. However, it is my opinion that it surpasses as an introductory text and goes on to describe in detail the structures of immunological components and provides an up to date account of various immunological mechanisms.

The authors have included recent experimental evidence to substantiate findings and therefore this book can be used by BSc as well as medical students. A chapter is devoted to describing the adaptive immune response and how it reacts to infections. It also deals with the non-adaptive host reaponses in another chapter. The final chapters integrate these systems and deal with defects in the immunological responses which include inherited disorders, AIDS, autoimmunity, allergy, graft rejection and the involvement of the immune response in attacking tumours.

A good proportion of medical students exhibit immunology avoidance behaviour and the size of this text book appears not to encourage overcoming of this phenomenon, however the text is very readable and the illustrations help to explain the sections that are a little heavy going. The text is presented in a logical fashion and each chapter is concluded by a summary.

So, why read this book in preference to the vast array of literature available on immunlogy? Well, for those of you medics that don't leave everything to the last minute before exams, it is actually an interesting text to read.

Immunobiology 2nd ed, Janeway & Travers, (Churchill Livingstone, ISBN 0443056587, £24.95)

Monica Sharma

Cognitive Therapy in Action - A Practitioner's Casebook

Cognitive therapy is one of the success stories of modern psychology. Developed in the last 30 years by Aaron Beck, its firm empirical grounding and practical nature have made it one of the most attractive therapies for patients with psychological problems. Mirroring cognitive therapy itself, 'Cognitive Therapy in Action - A Practitioners Casebook' is a well organised, practical handbook written by two leading clinical psychologists from the Newcastle Cognitive Therapy Cen-

tre whose honorary president is Professor Beck himself.

The book begins with a chapter on the evolution of cognitive therapy, outlining its philosophical roots, its methodological assumptions and some recent emerging themes. The authors' clarity of style and avoidance of jargon in these introductory 20 pages, set the pace for the rest of the book. Chapter 2 provides an important and succinct overview of the empirical basis of cognitive therapy, demonstrating clearly its usefulness in the treatment of a whole range of psychiatric disorders. The rest of the book consists of six detailed case studies of patients with depression, generalised anxiety disorder, panic disorder, obsessive compulsive disorder, bulimia nervosa and personality disorder. Each chapter is clearly structured and includes a defintion and a detailed description of the cognitive model of the relevant disorder, often summarised as a flow diagram. There then follows a description of the case and the progress during therapy, followed by the outcome. Together, these cases serve as an excellent practical guide for the aspiring cognitive therapist and as a mine of useful information and references for the researcher.

Although going for beyond the needs of the medical students, this book will prove to be an invaluable aid for clinical psychologists, psychiatrists, social workers, nurses and the keen intercalated BSc student. In short, it is a highly recommended, well written and practical illustration of how cognitive therapy works.

Cognitive Therapy in Action - A Practitioners' Casebook, Blackburn & Twaddle,(Souvenir Press, ISBN 0285632825, £12.9)

Andrew Parker

Physiology

If you are looking for the physiology alternative to the Letts A Level revision guides, look no further- this book provides the bare bones of physiology in a nutshell. It is an ideal revision aid for the 1st and 2nd MB, as it is geered towards preparing to pass exams.

The book itself is divided into chapters which cover the physiology of each system of the body. Each chapter begins with an overview followed by structural information ie relevant Anatomy and Histology. It then describes the main function of that system and how its performance is assessed. The bulk of the chapter explains the mechanisms that underlie these functions and how they are controlled. In order to include a clinical picture, there are examples of abnormal functions in each of the systems. The chapter is concluded by a self assessment section which incorporates MCQs, SAQs, essay questions and data interpretation

questions - essay plans and answers are also provided .

As mentioned earlier it is a superb revision aid and provides an excellent overview of physiology. However, for assessed essays a more detailed text will be needed. For those of you that find physiology a nightmare this book will definitely help to alleviate your anxiety. An excellent investment.

Physiology, McGeown, (Churchill Livingstone, ISBN 0443051968, £15.00)

Monica Sharma

Picture Tests - General Surgery

This addition to the Churchill Livingstone Picture Tests series is certainly an excellent one and appears to live up to the high standard set by the others. It is written by a trio of surgeons consisting of an SHO., an SR and a Consultant, thereby taking advantage of a broad spectrum of experience in the surgical field.

The book is composed of approximately 140 questions each of which is centered around a (clear) colour photograph, an X-ray, a CT scan or another type of radiological investigation. Following this, is a series of questions pertaining to the picture - these usually begin with either a description of what can be seen or the need for a diagnosis and possibly some differentials. The questions then progress in a logical manner asking about aetiology, associations, other investigations, to mention but a few and ending with treatment or prognosis. The advantage to this is that it gets the student *thinking* in a logical manner and hopefully better able to deal with ever inquisitive surgeons on those nerve racking ward rounds.

Although there is no substitute for actually observing things first hand on the wards or in theatre, it is very likely that a student will not get to see everything that he or she would like to - this book thus serves as a review of clinical conditions both seen before and those not come across. In terms of usage, at one end it can be used to look up conditions individually without prior knowledge while at the other, form a basis for rigorous testing of conditions (supposedly!) known about.

I feel sure that clinical students at all levels will find it an invaluable part of their surgical text collection especially preceding exams, when books such as these which allow self-testing are ideal to help build up much needed confidence.

If you haven't got General Surgery Picture Tests already, £9.50 is a small sum to consider paying for an excellent book that you will get full usage out of.

Picture Tests -General Surgery, Stiff, Fligelstone & Rhodes, (Churchill Livingstone, ISBN 0443051879, £9.50)

SSJ

Eric Dann (1930-1996)

It is with sadness that we report the sudden death on March 22 of Eric Dann, head groundsman at Honor Oak Park for 20 years.

Eric and his wife Joyce were well known to several generations of Guy's and UMDS students who used the School sportsgrounds. They were appointed together in 1975 and worked as a superb team, serving the School, its undergraduates and the many visitors to the pavilion.

On arrival in 1975 Eric immediately started a programme of ground improvement. New drainage systems and attention to the playing surfaces transformed the quality of the pitches. With characteristic enthusiasm and energy, he sustained their quality throughout the changing seasons over two decades. He always led his team of groundsmen by example and enjoyed the physical exertions of the job be it wielding a hammer or loading fertiliser onto a trailer. He and Joyce were resident at the ground and shared many responsibilities such as maintaining the pavilion. After a hard day Eric would take charge of the bar, his irrepressible spirit making it a focus of enjoyment. Both he and Joyce accepted the vagaries and sometimes unreasonable demands of undergraduates with stoicism. Their philosophy stood them well for they generated endearing friendships amongst the students, many of whom continued to use the fields after qualification, always certain of a generous welcome.

Eric was born in Surrey and after school he performed his national service in the Parachute Regiment. He enjoyed the rigours of army life but Joyce dissuaded him from a military career. He considered training as a pastry cook but then followed an inspired route to farm management at West Kingsdown Probation Home. He pursued a part time course in horticulture at Medway and Maidstone College and at the age

of 40 obtained a degree, emerging top of his class.

He was devoted to his family and married Joyce 47 years ago. Their loving nature was no better illustrated than by their adopting one of the boys from the probationary home. Tragically he was killed in a road traffic accident and it was this event which prompted Eric to apply for a vacant post at H.O.P.

Towards the end of his appointment he spent time improving and decorating a house in Eastbourne. Sadly he had little opportunity to enjoy retirement and his death followed only three weeks after a party held in Boland House in recognition of the contribution made by both Joyce and Eric to the life of the School.

His work lives on and the memory of his cheerful, energetic presence will remain fondly with many hundreds of students, and a circle of friends in Brockley. He leaves three children, 13 grandchildren and five great grandchildren. They all adored him. We shall miss him.

TG
SJC

Bruce Wotton

Bruce Wotton LDS RCS qualified at Guy's in 1944.

I first met Bruce some 50 years ago, in the early days of his marriage to Betty, who had served with my late wife in the Army Nursing Service during the war and whom he had met whilst serving in the Royal Army Dental Service in which his own father had completed a full and eminent career. During this period of close and valued friendship, as virtually, a member of Family, I was able to admire his qualities as a professional and as a member of Community and Society.

Bruce was for many years, in private practice in Western-super-Mare, until moving to Devon for the final phase of his career as a Dental Officer in the Local Authority Service for the young.

On retirement, he continued in Local Authority as a Parish and District Councillor, bringing to it the understanding, which would stem from a member of a caring profession, his particular interest was in conservancy where his concern was for restoration and maintenance rather than extraction.

He was a man of many parts, in the open air his lifetime interests had been in hunting, angling and boating, whilst in the arts his talent with the brush extended into the culinary field and I recall with nostalgia a number of cordon bleu menus, truly a 'Maitre Chef manque.'

He will be missed greatly by Betty, their three sons Simon, Stephen and Andrew, who bear testimony to the quality of parenthood, their young families and all those who came to admire and respect him during his lifetime.

Colonel J.F. Worth, OBE
Royal Signals, retired

Rugby

GUY'S 1st XV vs Jersey

Courage League London SW
17th February 1996
HOP Lost 0-7

Guy's learnt during the previous week of the reorganisation of the leagues for next season which meant that instead of one team being relegated three were proposed. The implications of this for Guy's were that, instead of a comfortable mid-league position, they would need another two points to be sure of safety. In the previous weeks Guy's had somewhat surprisingly lost to Old Alleynians who were second from bottom in the league whilst Jersey had had a fine victory over Warlingham 22-5. Thus the scene was set for an important and vigorous match. Guy's were showing a few changes in the side which appeared to be as much related to the kick-off being moved from 3.00 to 1.30 as to any injuries.

In the first 10 minutes of the match Guy's looked in control and won some good possession from set pieces. This resulted in two penalty chances at goal but Hughes standing in for Davies was unable to convert them. Jersey then began to get back into the game and, with some classy running, showed how dangerous they could be. However, Guy's defence held firm and, unusually, there was no score in the first half.

The second half was really to end stuff with penalties apiece being missed. However, the deadlock was eventually broken when, after a period of Jersey pressure, they eventually went over near the posts after a set scrum. In the event, this proved to be the only score of the match and, disappointingly, Guy's for the second week running had lost to opposition below themselves in the table. This was a game that Guy's could and should have won. It was disappointing that the team were showing four of five changes from our normal Saturday team and that several new faces were introduced to league rugby. Success at this level really does require commitment from all members of the squad, and, indeed, the administration if the Club is to continue to succeed. In spite of the loss, Guy's still played some very attractive rugby, and attempted to move the ball wide as often as possible. On one occasion Breeze caught a stray kick ahead at speed and almost made it to the line. He said later that with the extra yard of pace that comes from the avoidance of the culinary pleasures of life, he might have made it! Edward Hughes made a welcome appearance at stand-off and like so many Welsh stand-offs showed that distance in kicking appears to be inversely related to height. Davies played soundly at scrum half and

worked well with Ryan and Challacombe in the back row and Rose played steadily at full back. Overall, however, the team gave the impression of lacking the killer instinct and some cohesion which they will still need to be absolutely safe in the league.

Team: Hostert L, Edmondson M, Baladasaran D, Schofield B, Bod A, Ryan G, Challacombe B (captain), Martin, Davis J, Hughes E, Breeze R, Jenkins N, Hartwright D, Ekeowa U, Rose M.

SJC

Guy's Rugby Club Senior Players Tour (to Barcelona)

After successful trips to Budapest and Stavanger in the last two years, the third 'Senior Players' tour took place from 23rd to 27th May in Barcelona. A total of 24 players toured: five previous 1st XV captains and twelve vice-presidents including ex president Dr Terry Gibson. The age range was 23-53 years (mean = 35.6 years, standard deviation = 6.9 years).

In the first game against Club Hospitalet de Barcelona, Guy's were given an early shock, by a rather small opposition who were very proficient at setting up rolling mauls. However, Guy's lineout dominance and pace out wide (yes, some of us still do have pace) allowed the wingers to run in seven tries between them. A concerted effort by the opposition brought them three tries in reply but they were unable to catch up with the large Guy's lead. Some good breaks from Docker, at scrum-half and deft handling from the midfield trio of Bryant, Slater and Jones allowed the wingers Bevan and Bunting, and full-back Wilson to roam free. In the forwards, Martin, Williams, McKnight and Evans proved their fitness. Final score: 45-15 to Guy's. The evening entertainment involved singing Catalan folk songs as well as lessons in the ancient art of drinking from wineskins held at arms length. (Hint: don't spray the stuff in your eyes!). The second game was against a much tougher French side, Tournefeuille, from Toulouse. The battle was eventually won in the forwards, with the front row of Howell, Gibson and Neill proving effective despite a total age of 149 years. I'm sure the vociferous support from the Guy's men on the touchline was helpful here. Among the try scorers were Lowey and Barwell as Guy's ran out 15-10 winners. That evening a barbecue went on late into the night with the Spanish, French and Guy's teams demonstrating their singing powers. The Guys Welsh contingent gave a particularly fine rendition of Mae Hen Wlad Fy Nhadau even though Geraint Thomason didn't know the words. The remainder of the tour provided an opportunity to sample Spanish culture, Gaudi's Sagrada Familia and the Picasso museum proving popular. The crowded, narrow streets

of the intriguing Barrio Gotica area were teeming with Tapas bars and Asturian cider bars, and some of the party took the opportunity to have their pockets picked. (Suggestion; always keep your collateral in your Y-fronts!) All in all, the tour was a tremendous success, spreading the gospel of rugby a little further. Next year's tour will once again be over the second May Bank Holiday weekend, probably to Southern France. Anyone interested should contact Dr. Mick Martin on 0171 708 3067, or Dr. Terry Gibson via the usual channels.

'The victorious Guy's side applauded by Tournefeuille players.'

Guys II XV Season report 1996

W 10 L8 D1 F448 A 251

Another memorable year has past in the history of Guy's Hospital RFC 2nd XV. The year has had its ups and downs in terms of winning. But the games we did win were won in the usual champagne style rugby that the team only knows too well how to play.

The post match entertainment was just as memorable even if a little sketchy due to the few shandy's we consumed!

The team each week never really settled down to a set group of players partly due to job commitments but probably more due to borrowing of players on a Friday night/Saturday morning by my first team captain Ben Challacombe, thanks Billy!

Highlighting some of the more memorable points in the year, the first game against Old Guildfordians where we won 29-0 will always remind me what a shock being captain was. From only having eight players on the Friday night to walking on the pitch with fifteen and then winning was such a good feeling, continued in the Bar with the inaugural eight shots of dear fuel.

It was in this game that the characters of the 2nds really shone, the energetic running Jamie Coombes never allowed the games to get boring. Also John Costello in the centre epitomised the concept of crash ball centres. Both his side and his lack of passing helped this.

The season continued with the arrival of the new batch of freshers who were quickly inserted into the spaces on the team list. Players like James Harris (Bodyform), Dai Woodsford, Tim Hooper and all the other little freshers of whom there are far too many to mention. They all made their impact on and off the pitch and hopefully they

will continue to carry the honour of GHRFC through the difficult times of changes within the hospital.

The game mid season against Penzance & Newlyn away will go down in the record book as the game with the oldest centre partnership of 90 years. The two players aged 40 and 50 were undoubtedly the best player on the pitch but not surprisingly were borrowed from the opposition as we only managed to get 12 players on the five hour train journey down to Cornwall.

The game was lost and it started the trend for the next four games, which were defeats, however all were very close, (But then I'm bound to say that).

After the Christmas break the Hospitals Cup loomed and most training was encouraged so that we could retain the cup a fourth year running. However all didn't quite go to plan. The first game was due to be against Kings but after them postponing 4 times we won the match over the telephone. So our first real game was Charing Cross where even though the game wasn't of high standard we were victorious at 14-10. This lead us nicely into the showdown with St Mary's at London Welsh's ground.

The game has been written about so I shall just remind you of the devastating outcome of us losing 15-22.

As the Captain of the side I will always find that the saddest part of the season so far. I know everyone worked their hardest for that and even my player of the season Darren Jones scored his first try.

The final game of the season allowed us to finish on a high point where a 10 -7 point victory over a very annoyed Purley allowed us to return to the End of Season Dinner with some pride.

I wish all the best to next years Captains especially Johnny Spencer (Pete Morgan) who has the unenviable task of winning back that trophy which should be in our cabinet.

Thanks to all the players who I haven't mentioned, its been great fun being captain, and by the way, if you had forgotten, I scored the most tries in the season and I'm only a forward.

Barnaby Scholefield

Club Captain's Report. 152nd Season 1995-96

P 23 W12 L11 D0 F 502 A 519

At last its all over! No more endless phonecalls, continual training, constant worrying, niggling injuries and repetitive ginnings. This season has again proved this club to be full of highly competitive, intelligent and colourful characters.

We began in September with a couple of instantly forgettable games against London Irish and Esher (cheers Graham) but since then have improved steadily and barring two minor hiccups in the league after Christmas, may have even finished second. We unfortu-

nately had to let our coach go over the new year but the players responded magnificently with good wins over Old Walcountians and Alton. We retained the Boulger cup in October in our annual fixture against Old Reigations but this aside the season was one of 'if onlys and almosts'. The 1st XV lost in the cup quarter-final against Mary's when one of their players headbutted

Barney, Rich, Graham and Lutz (ever-present at training and drinking).

This year the oldest club enters a new era of uncertainty and change and I sincerely hope that we are able to stand together as a united club whatever the powers that be decide about the future of the unique and great GHRFC. One thing is certain, whatever our official title, the spirit and honour of playin

John Fry Dinner

The 9th John Fry Dinner for students of the 1940s will be held at Guy's on Wednesday October 16th. Dr J C Houston and Dr Bob Knight will be our guests. Anyone interested is invited to contact Dr R E Irvine, Dolphin House, Le Foulon, St Peters Port, Guernsey, GY1 1YY. A happy time among old friends is assured.

Back issues

Back issues of the Gazette are available from the Gazette Office at a cost of £2 + p & p. There are limited copies of most the previous issues.

Please contact the Office with your requests.

Changing Your Address?

Please give us SIX WEEKS' NOTICE of your move. This will help us to make sure your *Gazettes* continue to reach you.

PRINT YOUR NAME AND **OLD** ADDRESS	NAME
	OLD ADDRESS
	TEL. POSTCODE
THEN PRINT YOUR NAME AND **NEW** ADDRESS HERE	NAME
	NEW ADDRESS
	TEL. POSTCODE

Now cut out this coupon and send to:

Guy's Hospital Gazette
Boland House
Guy's Hospital
London Bridge
London SE1 9RT

NEW SUBSCRIBER
BANKERS ORDER SUBSCRIPTION FORM

Photocopies are acceptable

Please return completed form to:

Guy's Gazette
Boland House
Guy's Hospital
St Thomas' Street
London SE1 9RT
Tel 0171 955 5000 ext 5413/5414

To the Manager

_____ Bank plc

_____ Branch

_____ Address

_____

Please pay the sum of £15.00 annually on _____
commencing 19____ to the credit of:

Guy's Hospital Gazette
Account No. 80401269
Midland Bank plc
Southwark Branch
28 Borough High Street
London SE1 1YB

and debit my account accordingly:

Name (please print) _____

Account No. _____

Address _____

_____

Signature _____ **Date**_____

GUY'S

HOSPITAL GAZETTE

UMDS Guy's
9 OCT 1996
Library

August/September 1996

- Guy's Hospital Staff Round
- Thomas Hodgkin
- Interview with Professor R.A.C. Hughes

© Illustrazioni di Venezia, Italia

CONTENTS

290 Passim
292 Letters—One Club or Two, United Hospitals
293 Letters—Neglected Bodies, Bad Nursing
297 News—Architecture Observed, Rugby Club Run
299 Feature—Guy's Hospital Staff Round
305 Feature—Thomas Hodgkin
310 Feature—Interview with Prof. Hughes
315 Feature—Graduation Ceremony
322 Reviews—Practical Medical Microbiology
323 Nursing Notes—Spitting Image
325 Obituaries—Thomas Binns, Jean Hole
328 Sport—Rugby, Cricket
334 Classifieds & Announcements

UMDS Guy's
- 9 OCT 1996
Wills Library

Guy's Gazette

Editor Rikin Trivedi **Assistant Editors** Paul Hayden, Barney Scholefield **Sub Editor** Sue Ferguson **Features Editor** Kate Mundray **Review Editor** Susan Jain **Sports Editor** John Davies **Nursing Notes** Denis Cobell **Office Manager** Margaret Flanders.
Acknowledgement Dean Flanders.

The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

Volume 110 Number 2459 August/September 1996
ISSN 0017–5870

Guy's Gazette, Boland House, Guy's Hospital, London SE1 9RT. Tel (0171) 955 5000 ext 5413.
 All rights reserved.

Printed by Hobbs the Printers Ltd, Brunel Road, Totton, Hampshire SO40 3YS

Passim

Journalism is a powerful media tool; advertising even more so. The Guy's & St Thomas' Hospital Trust has recently relayed the results of the most recent Government published NHS performance tables to its employees. The report headlines would lead one to believe that the Trust is competing well in the market place. Indeed 5-star ratings were awarded for 22 catagories, including Paediatrics. However, the Trust doesn't seem so up to par on the majority of evaluated categories, including medical services. When one examines the entire report, one develops an entirely different impression of the same data. Creativity is also an excellent media asset.

In the Governments drive to match the ever excelling popularity of the Labour Party, it has developed new strategies to counter this rise in support for its opposition. The flavour of advertising campaign leaves the public questioning the morals, once again, of the Government. With slogans such as 'New Labour, no Union Jack; New Labour, no Britain', the Government are flirting dangerously with the slander and are neglecting the great moralistic responsibility that it has to the very people that elected them. Informed choice is one of the founding principles of our democracy; however this carries the assumption that those that provide this information are being both sincere and accurate in doing so.

I now close by saying on behalf of the editorial team a sad farewell the Gazette. It has been both a pleasure and a privilege to have served our readership and the Gazette over the past 18 months. The Guy's Hospital Gazette is the worlds oldest hospital journal, and whilst this year has seen the worlds oldest Rugby Club forced to lose its identity, this chapter in the history book of Thomas Guy's hospital still remains open. All that is left for me now is to introduce my successor; I leave the editor's seat vacant for Mr Barnaby Scholefield, who is very capable of maintaining the high standard of journalism that the Gazette prides itself on.

Thank you.

Letters

We would like to hear your views on any issues raised in any of the Gazettes, or anything to do with Guy's. You may have an opinion you would like to share with the rest of the readership. We would like to see some of your points published in future issues. If you feel you want to air your thoughts please write to the editor.

You are reminded that it is at the editor's discretion whether to publish a letter and that derogatory personal references to any individual will not be acceptable. We will however do our best to let you have a say.

One Club or Two

Dear Sir

We regret that the UMDS Council of Governors has urged Guy's Hospital Rugby Football Club to rename itself the Guy's and St. Thomas'-Hospitals Rugby Football Club of UMDS Subsequent to this request, a referendum of name choices was organised amongst the entire student body. Seventeen votes were cast for the Governors proposal, 134 for 'Guy's Hospital RFC (incorporating St.Thomas' Hospital RFC)' and 165 for 'Guy's and St. Thomas' Hospitals RFC'. The outcome was not unexpected in a constituency of people with limited interest in the rugby club. It was surprising that so many voted for a title that gave preeminence to the existing name. There was no opportunity to debate the issue at a United Clubs meeting and whenever the Guy's players themselves have considered the issue, there has been unanimous support for retaining unchanged the world renowned name of Guy's Hospital RFC.

St. Thomas' Hospital RFC had a venerable history but by the time the medical schools merged in 1982 it was failing to produce a single Saturday side and could not reliably find mid-week players. Since the formation of UMDS, the name of St. Thomas' R.F.C. has been perpetuated in the United Hospitals Cup competition and implicitly in the Wednesday UMDS sides. This arrangement was made possible by the support and organisation of Guy's RFC. It was an honourable and generous compromise which many hoped would endure.

Despite its demise, St. Thomas' RFC has remained registered with the Rugby Football Union although it has disappeared from the list of clubs in the Union handbook. It remains a source of nostalgia to some teachers in the School. Perhaps it was the impending relegation of Guy's Hospital itself which prompted the governors to urge on the students a rugby club name that reflected the merger of the Hospitals and Schools. Unlike these institutions, the renaming of Guy's RFC cannot celebrate a union of organisations or indeed of anything substantial since St. Thomas' Hospital RFC exists only as a name on a register.

Those of us who cherish the history and ethos of Guy's RFC feel hurt that the Club should be compelled to alter its name against the wishes of its players and supporters. We suspect that some of the Governors believe that there have been two active rugby clubs in the School. Motivated by the desire to ensure conformity and a spirit of unity, their proposal would have been appropriate if the existence of two clubs were true. As it is, we question the fairness and necessity of their decision.

Yours faithfully

I.A. Baker MSc MRCP

C. Howell FDS

C.E. Beardmore MB BS
S.A.G. Jones FDS D.Orth
J. Brazier BDS
T.L.T. Lewis CBE FRCS FRCOG
H.C. Burry FRCP
W. Llewellyn BSc
P. Chew BSc
M. Martin MB BS
J. Conchie BSc
A.G. Meharg BDS
K. Conchie BA
I.A. Neill BA HMCIO
A. Cook MS FRC
S.G. Parr BSc MRCP MB BS
J. Coombes BD
SN. Poole BDS
P. Cunnington MB BS
M. Popplewell BSc
J. E. Davies LRCP D Phys Med
M. Seare MSc
R. Docker BDS
N. Slater FRCS
S. Duckworth OBE MSc LRCP MRCS
G. Thomason MA MBA
T. Gibson MD FRCP
D. Stafford-Clarke MD FRCP DPM
W. P. Hogan MSc FIBMS
K. Underwood BDS M(Orth)
C. Thorburn MA MRCP
G.M. Preston Bsc MB BS MRCOG
G. Koffman FRCS

Vice Presidents
Guy's Hospital R.F.C.

United Hospitals

Dear Sir,

Since UMDS was formed fourteen years ago, we have attempted to bring together all the various activities into a unified structure. Apart from the Rugby Club all the sporting clubs have been unified under a name which recognises they cover both Guy's and St Thomas'.

The existence of two separate rugby clubs was causing confusion outside the School and unnecessary contention within. The student body wishes to have a single club and indeed this was also the view of the Guy's Hospital Rugby Club, expressed at a meeting that I attended earlier this year. What remained in dispute was the actual name of the unified club. Accordingly, the matter was discussed in detail by the council of Governors. The views of the Guy's Hospital Rugby Club were expressed to the council by the President of the Club, who is a member of the Governing Body. After a very full discussion, the Council determined that both hospital's names should appear in the official name of the club and asked that the students should be consulted about the decision. The students decided to hold a referendum and the results was that the majority wished the single club to be called The Guy's and St Thomas' Hospital Rugby Football Club.

I am aware that some are not happy with this decision but I can assure

everyone that the matter has been carefully considered indeed, not least by the council of Governors, and the final decision follows the wishes of the majority of the students and they after all, are the most important group to consider. UMDS values the Rugby Club highly and I recognise and am grateful for the contributions of the young and less young to its continued success. We all hope that its future will be as glorious as its past.

Yours faithfully,

C.Chantler
Principal

Neglected Bodies

Dear Sir,

Denis Cobells faintly cynical little piece Holy Hearts (Guy's Gazette June 1996) leaves a less than pleasant taste with its sneering references to 'bible bashing', 'payment of parsons' and 'institutions having a religious connection despite gaining some of their funds from the public purse'. Can it be that the nursing profession , having begun, it seems, to be somewhat more neglectful of the body than in the days gone by, would have us begin to neglect the spirit too?

Yours Faithfully

Derek Wilkins

Bad Nursing or Bad Humanism

Dear Sir

I was disappointed to read Denis Cobell's article "Holy Hearts" in your June issue. He and I have disagreed before in your journal about the function of organised religion in hospital. I still believe that Guy's Gazette is not the appropriate forum for our disgreement, but his article cannot go unanswered and demands a reply.

Of course he is right. There is bad religion and it has no place in hospital, any more than bad medicine, bad nursing, or - dare I say - bad humanism. Any of these activities becomes bad when it hinders, rather than promotes, the process of recovery which ostensibly is its aim. Of course he is right in highlighting an instance of bad practice, but that in itself does not vitiate all the consistency of good practice whether in chaplaincy, nursing or the practice of medicine.

But in his eagerness to make the most of a useful springboard to launch into an anti-religious offensive, he overlooks two important points. First, the religious group who came to take the ward service could not have been there without the consent and co-operation of the nursing staff. I believe it is part of the advocacy role of the nurse on behalf of the patient to get rid of any unwelcome visitors, religious or other-

wise, who are disturbing the ward and causing stress to patients.

Secondly, I presume his column is primary intended for the discussion of nursing matters. To use it as a platform for the promotion of anti-religious arguments in favour of his own brand of humanism is essentially the same as what the religious group were doing - about whom he complains so vehemently.

Yours faithfully

Rev. Neville Smith
Guy's Hospital Chaplain

Right to Reply

Dear Sir,

I have been invited to reply to your two correspondents re. my article, 'Holy Hearts' in the Gazette June 1996.

Rev Neville Smith has graciously agreed I was right! But he does not consider the Gazette a suitable forum for the discussion of religious matters; I should keep to nursing, he believes. I would like to be able to agree with him; and was arguing that medical and nursing approaches to patients should exclude religion except when there is a wish for help of this nature.

Further more, he seems to support my position that the sort of religious group who irritated the patient I quoted should not have been there without consent. But whose consent? Seemingly not these of the patients' in this instance.

The professor whose article in the nursing times initiated me essay also asked whether a prosely tising humanist group would have been given similar access. He doubted if this would be accepted; he neither wanted it, nor do I. However it may be of interest to Rev Smith to note the following, which I have gleaned from proposals to enable humanists to have access to patients in hospitals, wanting a service on the same footing as offered by the clergy. This is a situation denied at present.

More significantly, these quotations come from a Government sponsored document, emanating from the Leeds University Institute of Nursing: 'Modern thinking tends to associate spirituality synonymously with religion and a belief in God; adopting such a narrow approach is to exclude may people who may not share such beliefs...'

Recently, MORI poll found 10% of the population have views consistent with humanism, who may need pastoral care, which this document stated; 'is important for all people, not only those who express a religious belief'.

Maybe this also goes some way towards answering the latter part of Dr Wilkins' query. I hope his opinion that the nursing profession is somewhat neglectful of the body is a temporary lapse; a view which he will no doubt recover from once he notices the achievements of modern nurses at Guy's and elsewhere

Yours faithfully,

Guy's Hospital
MEMORABILIA

Unique items available only from the Gazette

Specially made, limited edition Guy's crested car badges. Grey background, black shield with silver lions, gold crowns and blue fleur-de-lis on a gold chevron. The motto is displayed on gold scrolls with black lettering. Frame forged in solid brass finished with deep chrome plate.

Price £25 each + £1 p&p

To: The Manager
Guy's Hospital Gazette
Boland House
St Thomas' Street
London SE1 9RT

I enclose a cheque/PO for £ .....
NAME: .....
ADDRESS: .....
.....
Tel:.....

Please make cheques payable to Guy's Hospital Gazette

Office hours: Monday to Friday 1-5 pm. Personal callers welcome.

Architecture Observed

A former Guy's graduate, Neil Watson (graduated 1967), has recently had his artistic talents acknowledged by the world of art in a recent exhibition of his drawings and paintings at the Schola dell'Arte dei Tiaoro e Battioro next to the San Stae church, Venice, Italy from June 1st to August 31st 1996.

This exhibit was entirely devoted to architectural subject matter. It was the artist's opinion that the key to understanding architecture, and being able to communicate it visually, is through observational drawing. He has just completed a book about this, due to be published by WW Norton in 1997. In recent years training in observational drawing, both in art schools and schools of architecture, has been under-emphasised, though the tide is now turning as it becomes clear, even to those who denied it that drawing skills are still a pre-requisite for artistic and architectural success, even in the age of the computer. The works were displayed in groupings, showing the development from initial drawings, almost all done on location, to finished works in varying styles, many of them done in series. Indeed working in series was an important part of artistic development since it, allowed the artist to focus on pictorial issues and to be freed up from issues of simple depiction. The works represented his personal reaction to, or response to, architecture, rather than an accurate description of it, though some of the works were much more 'realistic' than others. Most of the drawings and paintings were of Venice and were the result of a visit to Venice by the artist in 1995. But there were also works featuring buildings in England and in the United States, where the artist, who is English, now lives.

One of the key issues that has confronted artists, particularly those of the twentieth century, is that of space. In particular the question of whether architecture is communicated in deep space, where there are major perspective matters to consider, or in shallow space, where there are fewer perspective issues. For the student of art or architecture the most important aspect of perspective is that of experienced perspective, which embodies those phenomena of visual perception which are called constancies. Architectural subject matter depicted in constructed perspective, or derived entirely from photographic reference material, always appears unnatural, because we simply do not see the world that way. More particularly it is the artists' view that architecture depicted in shallow space allows of a more personal, and more intimate, interpretation. The 'long' view, in conventional perspective anyway, has been done so many times, especially in Venice, that it is harder to be original.

(see inner front and back covers).

Guys Hospital Rugby Club Runs For Charity

Last year saw the biggest effort in Guy's Hospital RFC's continuing support for the Evelina Children's Appeal.

A few weeks prior to the tour to South Africa, when fitness levels were high, the Rugby Club organised a sponsored run up to the Guy's tower; the fourth highest building in London.

Such an event had been attempted before by the club, though not on such a large scale, and without the success which accompanied the club on this occasion.

The aim was to ascend thirty floors on foot as many times as possible, aspiring to the ominous target complete ascents. Completing this would mean that the runners had effectively ascended just under a third of the height of Everest!

Fifteen representatives of the touring squad ran, having already handed in their sponsorship forms to the organiser. Patrick Gush, who during the run, publicised the event in the reception area of Guy's tower; drawing much public support for the cause.

The target seemed a long way off, and the lift was a welcome break for the descent; we judged that to descend on foot would be unnecessary and detrimental. However, having pressed the half-way mark of ten ascents, our hopes were raised alleviating the heavy legs, and the support at the bottom of the tower urged us on to yet another ascent, again and again.

The result was that most of the runners completed fifteen ascents, with five runners completing the full twenty ascents. These runners were:- Prodip Das, David Fearns, Ben Challacombe, Marcus Sharp and Andrew Williams.

This success and other fund-raising events, such as collections at Twickenham and a tombola held at the annual Rugby Club ball, meant that in November 1995, Professor S. J. Challacombe, President of the Guy's Hospital RFC, was delighted to be able to present a cheque of £1000 to Sylvia Sutton and Dr Michael Joseph of the Evelina Children's appeal.

It is hoped that a similar event will be held this year to raise more funds again for the Evelina Children's Appeal in the run up to the Guy's Hospital Rugby tour to Canada

'Cheque being presented to the Evelina committee.'

Guy's Hospital Staff Round: Case Reports

Transient blindness following renal transplantation

Severe hypertension or the use of certain immunosuppressive drugs can induce a condition termed the *'reversible leucoencephalopathy syndrome'* characterized by altered mental function, visual loss, stupor and seizures. In this report, we present a case associated with the use of cyclosporine in a renal transplant recipient.

Case history and clinical findings

A 47 year old businessman received his first cadaveric renal transplant. He had first been investigated eight years previously because routine blood tests had demonstrated significant renal impairment (serum creatinine 219mol/l). There was a strong family history; his father had died age 43 of end-stage renal failure, and two siblings had also developed end-stage renal failure. Urinalysis - trace protein, no blood, normal sediment. An intravenous urogram demonstrated smooth, slightly shrunken kidneys. Serum urate levels were raised at 0.63 mmol/l and uric acid studies suggested a diagnosis of familial gouty nephropathy. The patient was treated with allopurinol and antihypertensives, and progressed to end-stage renal failure over the next five years. He was treated with continuous ambulatory peritoneal dialysis until he received his transplant.

The cadaveric graft was from a cytomegalovirus (CMV) positive donor (the recipient was CMV negative). Immunosuppression consisted of Prednisolone (1/3 mg/kg) and Cyclosporine (8 mg/kg in two divided doses using the Neoral preparation). Azathioprine was started at 2mg/kg at day 5. There was primary function of the transplant kidney although the creatinine only fell slowly. By day 7 serum creatinine was 397mmol/l and a transplant biopsy showed acute cellular rejection. The patient received three daily infusions of 1g methylpred-

nisolone. On day 20 serum creatinine was 362mol/l, trough cyclosporine level 415ng/ml and a further renal allograft biopsy showed ongoing acute cellular rejection. He was treated with a further three grams of intravenous methylprednisolone and 10 days of antilymphocyte globulin. He also received a 10 day course of intravenous ganciclovir as prophylaxis against CMV disease. On day 24 a transplant arteriogram showed no evidence of a renal artery stenosis.

On day 37 he was readmitted with the sudden onset of headache, confusion, drowsiness, slurring of speech and complete blindness. Shortly after being admitted he developed three tonic-clonic seizures. He was afebrile, pulse rate 84/min and blood pressure 192/104. Examination of the cardiovascular, respiratory and abdominal systems was unremarkable. Pupillary reflexes to both light and accommodation were present but perception of light was absent (cortical blindness). There was arteriolar narrowing and arteriovenous nipping, but there were no retinal haemorrhages and no papilloedema. Cranial nerves were otherwise intact. Tone was increased in the arms and legs, and reflexes were generally brisk, with knee and ankle clonus. The patient was disorientated in time, place and person.

Investigations: Hb 9.9 g/dl, WCC 8.4 $x10^9$/l and platelets 134 $x10^9$/l. Sodium 137 mmol/l, Potassium 3.9 mmol/l, Urea 19.2 mmol/l, Creatinine 368mol/l, Glucose 4.9 mmol/l , Calcium 2.31 mmol/l, Magnesium 0.6 mmol/l, Total Cholesterol 3.2 mmol/l, Triglycerides 2.1 mmol/l and trough Cyclosporine level 223ng/ml. Blood and urine cultures grew no organisms. An urgent CT head with intravenous contrast was normal. A lumbar puncture was performed. CSF Glucose 3.4 mmol/l, Protein 0.4 g/l; 20 red cells and 4 white cells/l CSF. Gram stain and culture of the CSF were negative. PCR of the CSF for CMV, herpes simplex and herpes zoster viruses was negative.

The initial clinical impression was that the patient had a generalized encephalopathy due to either hypertension, drugs such as cyclosporine, or a viral encephalitis. His blood pressure was controlled with labetalol, cyclosporine was discontinued and intravenous acyclovir administered. Within twelve hours there was a dramatic improvement with return of vision. Due to the speed of recovery, viral encephalitis was ruled out and acyclovir discontinued.

An echocardiogram showed no evidence of valvular heart disease making embolic disease unlikely. Electroencephalography demonstrated frequent

bursts and short runs of slow activity most evident posteriorly. Magnetic resonance imaging performed the day after admission (Figure 1) showed bilateral white matter abnormalities in the occipital lobes which had completely resolved on a repeat scan on day 52. Positron emission tomography using FDG on day 40 (Figure 2) showed diffusely reduced uptake in the whole cerebrum, compatible with a generalized encephalopathy. A repeat FDG scan on day 101 showed a completely normal pattern of FDG uptake.

Figure 1 - MRI scan performed 36 hours after the onset of symptoms showing white matter lesions in both occipital lobes.

The patient's blood pressure was controlled and cyclosporine stopped. There was complete recovery of his cognitive function and vision. However the renal allograft function deteriorated and a further biopsy showed ongoing acute cellular rejection. It was decided that it would not be wise to increase his immunosuppression and on day 46 a graft nephrectomy was performed and immunosuppression stopped.

He was recommenced on peritoneal dialysis, and apart from a mild CMV seroconversion illness he has been well since.

Discussion

This case exhibits the classic features of a reversible posterior leucoencephalopathy syndrome[1], which has distinctive clinical features and white matter changes in the posterior parts of the brain on neuroimaging . This syndrome has been described in patients with hypertensive encephalopathy[1,2] eclampsia[1,3], acute intermittent porphyria[4] and patients on cyclosporine[1,5,6] and tacrolimus[1,7]. Hinchey et al[1] performed a retrospective search of the log books listing all CT and MRI studies performed at two centres and found 15 such cases which had been investigated between 1988 and 1994. Four patients

Figure 2 - FDG positron emission tomograms performed at 72 hours (panel A) and 9 weeks (panel B) after the onset of symptoms. The first scan shows globally decreased uptake of FDG consistent with a generalized encephalopathy, whilst the second scan shows a normal uptake.

were on cyclosporine, three on tacrolimus, one on interferon alfa for malignant melanoma, four had acute hypertensive encephalopathy on the background of preexisting renal disease and three had eclampsia. The most common clinical symptoms and signs are headache, altered conscious level, seizures and abnormalities of visual perception ranging from blurred vision to frank cortical blindness. The tendon reflexes are often brisk, and some patients have weakness and incoordination of the limbs. Neuroimaging shows white matter oedema, especially bilaterally in the parieto-occipital regions. The calcarine and paramedian occipital lobe structures are usually spared, a fact that distinguishes the syndrome from bilateral infarction of the posterior cerebral artery territory. Involvement of the brainstem, cerebellum, basal ganglia and frontal lobes has also been reported. Why the posterior part of the brain should be differentially affected is not known.

Sudden elevations in systemic blood pressure cause a breakdown in autoregulation leading to vasodilatation, a breakdown of the blood-brain barrier and transudation of fluid. The cerebral white matter is composed of myelinated fibres in a cellular matrix of glial cells, arterioles and capillaries that make this area sensitive to the accumulation of fluid. Rapid resolution of clinical symptoms occurs on lowering the blood pressure.

The mechanism of the neurotoxicity of cyclosporine and tacrolimus is uncertain. Risk factors that have been identified include high cyclosporine trough levels, hypertension, hypocholesterolaemia[5], hypomagnesaemia[8], high dose intravenous methylprednisolone treatment, aluminium overload and preexisting central nervous system abnormalities[8]. Whether the Neoral preparation of cyclosporine with its greater bioavailability is more toxic remains to be seen. Cyclosporine could damage the blood-brain barrier by various means: direct toxic effects on the endothelial cells, vasoconstriction caused by release of endothelin and disturbance of the prostacyclin/thromboxane axis or microthrombosis as in the haemolytic uraemic syndrome.

The causes of the posterior leucoencephalopathy syndrome are multifactorial. It is crucial to recognize the syndrome early because blood pressure control and discontinuing the offending drug leads to prompt resolution of the symptoms. Failure to recognize the condition can lead to fatal brainstem compression due to a hyperacute cerebellar swelling[9].

References

1) Hinchey J, Chaves C, Appignani B. et al (1996) A Reversible Posterior Leukoencephalopathy Syndrome. N. Eng. J. Med 334:494-500.
2) Sheth RD, Riggs JE, Bodensteinier JB et al (1996) Parietal occipital oedema in hypertensive encephalopathy. Eur Neurol 36:25-8.
3) Raroque HG, Orrison WW, Rosenberg GA. (1990) Neurological involvement in toxemia of pregnancy: reversible MRI lesions. Neurology 40:167-9.
4) Kupferschmidt H, Bont A, Schnorf H. et al (1995) Transient cortical blindness and bioccipital brain lesions in two patients with acute intermittent porphyria. Ann Intern Med 123:598-600.
5) de Groen PC, Aksamit AJ, Rakela J. et al (1987) Central nervous system toxicity after liver transplantation: the role of cyclosporine and cholesterol. N. Eng.J.Med 317:861-6.
6) Thompson CB, Sullivan KM, June CH. et al (1984) Association between cyclosporine neurotoxicity and hypomagnesaemia. Lancet ii:1116-20.

7) Shutter LA, Green JP, Newman NJ. et al (1993) Cortical blindness and white matter lesions in a patient receiving FK506 after liver transplantation. Neurology 43:2417-8.
8) Tollemar J, Ringden O, Ericzon B-G, Tyden G. (1988) Cyclosporine associated central nervous system toxicity. N.Eng.J.Med. 318:788-9.
9) Pullicino P, Zimmer W, Kwen P. (1996) Posterior leucoencephalopathy syndrome. Lancet 347:1557.

James Pattison, Gwyn Williams, John Taylor and Geoff Koffman.
Departments of Nephrology and Transplantation, Guy's Hospital.

Thomas Hodgkin

Another great eponymist at Guy's!

Visitors to the Gordon Museum are amazed and delightful to find, side by side, the original specimens of Addison's disease, Bright's disease and Hodgkin's disease. It is therefore surely incumbent on every student at UMDS to make sure that he or she becomes familiar with these unique pieces of medical history and the names behind them.

The life and career of Thomas Hodgkin are in many ways the most remarkable of this famous trio. He was born in Pentonville, then, at the end of the 18th century, a village north of London. His parents were Quakers and both were private tutors. Much of Hodgkin's subsequent career can be explained by his firm religious faith.

After a period as a chemist's apprentice, Thomas entered the United Hospitals of St Thomas' and Guy's in September 1819, but transferred to the University of Edinburgh a year later. A further year was spent in Paris, where he was most impressed by René Laennec, who had invented the stethoscope and who was revolutionising the study of diseases of the chest. Hodgkin delivered a paper on Lannec's work at the Guy's Hospital Physical Society in 1822, and was one of the first to introduce the stethoscope into clinical practice in this country.

'Hodgkin was one of the first to introduce the stethoscope into clinical practice in this country.'

In 1823, Hodgkin qualified at the University of Edinburgh. His dissertation (in Latin) was on physiological methods of absorption in animals. In December 1825 he became a Licentiate of the Royal College of Physicians and obtained the appointment of Physician to the London Dispensary in Whitechapel, which provided out-patient care to the vast numbers of sick poor. In the same year came his important appointment as Lecturer in Morbid Anatomy and Curator of the Museum at Guys' Hospital Medical School, which had just become independent of the United Medical School and whose new building opened the following year. Hodgkin provided both enthusiasm and originality to this post. At that time pathology was an optional part of the curriculum in which

there was no examination. He introduced his first lecture as follows: 'to those who may place the (purpose) of medical practice in converting the largest quantity of physic into gold, morbid anatomy must, I am aware, be the object of disgust rather than attraction. But those who are aspiring to become worthy members of the profession which has for its object the restoration of health will see that morbid anatomy constitutes a study most essential to their art. I can see no palliative for the presumption of those who profess to administer the remedy without the knowledge of the disease'. Words that could be well used by any professor of pathology today. His concluding words were equally rousing: 'I shall conclude by assuring you that it will by my constant aim to co-operate with those who are strenuously endeavouring to render the school of Guy's Hospital the first medical school in the Kingdom'.

'to those who may place the (purpose) of medical practice in converting the largest quantity of physic into gold, morbid anatomy must, I am aware, be the object of disgust rather than attraction.'

'I shall conclude by assuring you that it will by my constant aim to co-operate with those who are strenuously endeavouring to render the school of Guy's Hospital the first medical school in the Kingdom.'

As an assistant, Hodgkin had the artist and wax modeller Joseph Towne, then aged 18, whose splendid wax models can be studied with great benefit in the Gordon Museum today.

Hodgkin began to assemble specimens for his new museum. The catalogue published in 1829 contained details of 1677 specimens arranged to display the effects of particular diseases on different organs. He soon became recognised as the foremost morbid anatomist of the day.

In 1832 a paper by Hodgkin was published in the Journal of the Medical and Chirurgical Society entitled 'On Some Morbid Appearances of the Adsorbent Glands and Spleen'. In this he described six cases which he had encountered at Guys' and a seventh case attended by Lugol in Paris. He acknowledged that the

condition he was describing was probably already familiar to many morbid anatomists but the condition was a fatal disease, distinct from tuberculosis, in which many lymph nodes throughout the body became enlarged. In 1856, Samuel Wilks documented 36 cases in the Guy's Hospital Reports and in 1865 assembled another 60 cases in the same journal. Wilks then became acquainted with Hodgkin's description of 1832 and, when credited with the original description of this condition, he was at pains to draw attention to Hodgkin's prior claim, and the term 'Hodgkin's disease' persists to this day.

Interestingly enough in 1926, Herbert Fox carried out microscopic examinations of the six preparations in the Gordon Museum; he found Hodgkin's disease in three, tuberculosis in one, syphilis in one and a non-Hodgkin's lymphoma in the sixth..

In 1837 a vacancy on the staff at Guy's as Assistant Physician resulted from the promotion of Thomas Addison to Full Physician. Hodgkin failed to be elected and promptly resigned his position at Guy's Hospital. His failure was almost certainly due to his appointment being opposed by Benjamin Harrison, Secretary at Guy's and a member of the committee of the Hudson's Bay Company. He was well familiar with Hodgkin's deep interest dating from his student days in the exploitation of 'aboriginals'.,a term then applied to native populations throughout the world who were being exploited by European settlers. Hodgkin himself had campaigned about the treatment by the Company of the Indians of the Hudson's Bay region.

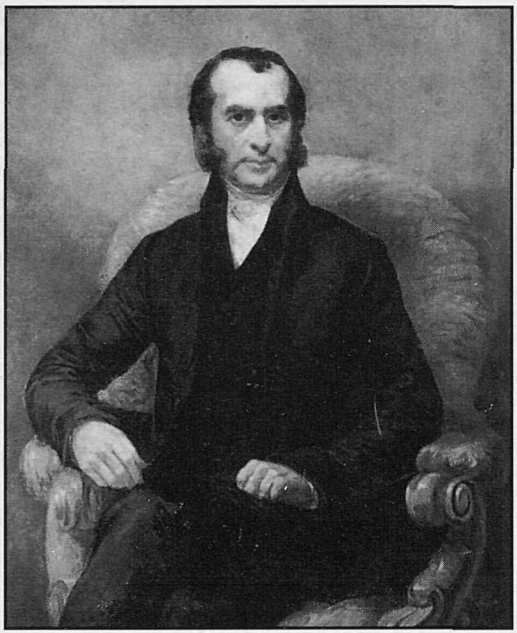
From 1837 onwards, after a short and meteoric career as a morbid anatomist of just a dozen years, Hodgkin devoted the rest of his life to affairs outside of hospital practice. He continued to see patients, both rich and (especially) poor, was deeply concerned with the Aborigines Protection Society, which he was more or less instrumental in founding, was a member of Senate of the University of London and was connected with many learned scientific societies.

'...relief of the Jews of the region who were suffering from an outbreak of cholera and by a plague of locusts.'

During the last ten years of his life, Hodgkin was frequently in the company of the Jewish philanthropist, Sir Moses Montefiore, to whom he acted as personal physician. With Montefiore, Hodgkin made numerous trips abroad, especially to

Palestine. Their final trip to the Holy Land was in the Spring of 1866 with the aim of assisting in the relief of the Jews of the region who were suffering from an outbreak of cholera and by a plague of locusts. Hodgkin became ill and died in Jaffa on 4th April 1866 in his 68th year. He was buried in the small Protestant cemetery in Jaffa where his tomb, once sadly neglected, but now restored, can be visited to this day.

Professor Harold Ellis



Thomas Hodgkins 1798-1866
This picture can be found hanging in the Gordon Museum at Guy's

Guy's Hospital
MEMORABILIA

Unique items available only from the Gazette

English Pewter Tankards and Goblets, engraved with the Guy's Crest, available only from the Gazette, individually boxed.

Price £22 + £1 p&p

ORDER FORM

Name .....

Address .....

Tel: .....

Please send me .... *Guy's Goblets at £22+£1 p&p*

.... *Guy's Tankards at £22+£1 p&p*

I enclose a remittance of £ .....

To: The Manager, Guy's Gazette Office,
Guy's Hospital, London SE1 9RT
Tel: 0171 955 5000 ext 5413

Personal Callers Welcome

Office hours: Monday to Friday. 1–5 p.m.

An Interview with Professor Richard Hughes

A Guy's man born and bred

Richard Hughes began his medical career at Cambridge studying pre-clinical medicine before moving to Guy's for his clinical training and subsequently qualified from Guy's Hospital in 1967. His first House Job was in William Gull ward at Guy's followed by a House Surgeon's post at Guilford. SHO posts at the Hammersmith and the Royal Brompton hospitals followed before returning to Guy's as a junior lecturer in general medicine under Professor Lessof. Staying at Guy's, he undertook a registrar post in neurology followed by a MRC research fellowship with Professor Leibowitz studying experimental neuropathology. A brief period away from Guy's then ensued as he went to the National Hospital for Nervous Diseases, the 'Mecca' for neurology in Britain. On April Fool's day, 1975, he was appointed as a consultant in neurology at Guy's and, apart from a year's sabbatical in San Diego in 1982, has remained here ever since.

Why did you choose Guy's Hospital?

Well, I'm pretty well Guy's born and bred. My wife was a Guy's nurse and my brother was a Guy's doctor as were two of my cousins. One of them is also married to an ex-Guy's doctor who is also a member of a large Guy's family. The other is also married to a Guy's nurse.

My father was a Guy's doctor who married a Guy's Sister. Her eldest sister was also a Guy's nurse. My Grandfather, 'Joey' Hughes, was senior surgeon at Guy's and is probably well known to an older generation of Guy's people. He too married a Guy's nurse. As well as this, his eldest brother was a medical

student at Guy's who was unfortunately killed during the Boer War and his father, my Great-grandfather, was also a Guy's doctor.

I remember during my interview at Guy's I was immediately welcomed by the consultants who all said how well they knew my parents! This was quite disconcerting for a young man, such as myself, eager to succeed on the strength of his own merits.

How did your interest in neurology develop?

I started with an interest in neuroanatomy, generated by my tutor at Cambridge and enhanced by the privelige of studying in Hodgkin's department in the year he was awarded the Nobel Prize. I subsequently became fascinated by the intricacies of the nervous system as a whole and later on this developed into an interest in the effects of disease on its functioning.

What are your current research interests?

I am particularly involved in inflammatory neuropathies, autoimmune neuropathies, and Guillain-Barré Syndrome with a broader interest in neuroimmunology. My current work is really specialized around the cause and treatment of inflammatory neuropathy, specifically GBS.

How did you become interested in Guillain-Barre Syndrome?

My MD thesis was on an animal model of experimental allergic encephalitis which is analogous to multiple sclerosis so I suppose it was this that really started my interest in this type of disease. Then, as a senior registrar, I noticed that whereas the oncologists were beginning to improve leukaemia treatments using controlled trials, the neurologists were sadly lagging behind with no satisfactory clinical trials for GBS, so we undertook a clinical trial using steroids which was in fact the first multi-centre clinical trial for treatment of GBS. Unfortunately this didn't work but it developed my interest in clinical trials and just recently, we have completed a huge multi-centre trial for the treatment of GBS with plasma-exchange and immunoglobulin.

GBS, although rare, is important because it is an example of a demyelinating disease that occurs in the peripheral nervous system and is therefore more amenable to research than those disorders that occur primarily in the brain such as multiple sclerosis. For example, we commonly take peripheral nerve biopsies from our patients for research purposes and as a diagnostic test and

have used these samples to make significant advances in our knowledge of the disease.

You are well known for your dedication to the 'Save Guy's' Campaign. What has been happening recently?

Until a year ago, the whole process of change within Guy's and St Thomas' was a matter for public consultation and so everyone had a right to contribute, which those of us with a long association with Guy's were determined to do. I think we all felt that it was important to harness the great spirit that exists at Guy's, and indeed at St Thomas', in the best possible way. We were very unhappy with the government's decisions at the time and so we joined with the considerable public movement to campaign for the future of the hospital.

However, the situation now is different as the matter is not open to public consultation anymore but is to be decided within the Trust. It is therefore vital that we all contribute to get the best from the government's solution for the hospital. This is best achieved by discussion within the Trust and the medical school and is not really suited to the marches and public announcements of the last year.

The amalgamation of Guy's and St Thomas' has proved to be a highly successful combination and we must now look forward to the union with King's College. I am concerned that more emphasis should be placed on the needs of the medical school in the future. Although our hospitals are great institutions, physical separation of clinical academic departments on to a different campus from their in-patient base would be a significant disadvantage and should be avoided.

How will the merger with King's affect the neurology department?

Neurology has its own unique problems that need to be addressed. The field can be sub-divided into general neurology and specialist, or tertiary, neurology which is what I tend to specialize in. At present, it has been proposed that ultimately out-patients will remain at Guy's, along with the academic unit, general neurology wards will be at St Thomas' and the specialist neurology will move over to the King's site. As you can imagine, this may prove to be quite a logistical feat for us. However, the stimulus of joining up with King's College will make the challenge worthwhile.

Where do you see research going in the next few years?

It is a very exciting time at the moment for neurology, particularly in terms of neuro-genetics, improved immunosuppressants and trophic factors. In the case of immunosuppressants, I feel that we will soon develop less toxic drugs which are also more specific that can be used to treat autoimmune diseases of the nervous system. At the moment, the progress of beta-interferon for multiple sclerosis looks promising and we are taking part in a large trial of its use at the moment.

Research from developmental neurobiology is also very exciting especially concerning the use and understanding of trophic factors. These may be able to be used to prevent nerve death and assist in repair following damage. In severe GBS, axonal damage occurs as well as the destruction of the myelin sheaths and results in severe persistent paralysis in about 10% of patients. We hope that neurotrophic factors may be helpful in preventing this permanent nerve damage.

Could you describe a typical week in the life of Professor Hughes?

I start work at 7.30 am catching up with correspondence which lasts until 9.00. Monday tends to be a pretty straight-forward clinical day. Tuesdays are spent with research clinics on MS or GBS for example followed by keeping up to date with my PhD students and research fellows. Wednesday mornings are clinical with afternoons spent editing 'The Journal of Neurology and Neurosurgery & Psychiatry'. Thursdays are a mixture and Friday mornings I spend down at King's with about 50 neurologists and neuroscientists which is very stimulating and enjoyable. Outside the National Hospital for neurology and neurosurgery, this is the largest collection of neuroscientists and neurologists in the country. On Friday afternoons and the weekends I catch up ready for the next week!

Which aspect of your career do you enjoy the most?

I have never been able to answer that question but I suppose if I was forced to choose one, then it would have to be my clinical work.

Paul Hayden

NEW SUBSCRIBER
BANKERS ORDER SUBSCRIPTION FORM

Photocopies are acceptable

Please return completed form to:

Guy's Gazette
Boland House
Guy's Hospital
St Thomas' Street
London SE1 9RT
Tel 0171 955 5000 ext 5413/5414

To the Manager

_____ Bank plc

_____ Branch

_____ Address

_____

Please pay the sum of £15.00 annually on _____
commencing 19____ to the credit of:

Guy's Hospital Gazette
Account No. 80401269
Midland Bank plc
Southwark Branch
28 Borough High Street
London SE1 1YB

and debit my account accordingly:

Name (please print) _____

Account No. _____

Address _____

_____

Signature _____ **Date**_____

Graduation Ceremony

Address to the class of 1996, Thursday 4th July 1996.

May I first add my welcome to that of the Vice-Provost and thank him for allowing us once more to use this splendid cathedral for our Graduation Ceremony. As you have heard it is particularly appropriate that we should do so because it was here, or at least on the site, that our history began.

It is a particular pleasure also to welcome the Vice-Chancellor of the University of London, Professor Andrew Rutherford, who has joined us on this platform party. Also with Lord Butterfield on the platform and most welcome are Sir Kenneth Eaton, Chairman of the Guy's and St Thomas' Hospital Trust and my fellow Deans' Professor Phillips, Professor Williams, Dr Thomas, Dr Cochrane, Dr Rees and Dr Bateman. Professor Neal is Chairman of our Academic Board, Professor Burnand is Professor of Surgery and Professor Ellis is the best known person in UMDS. He was Professor of Surgery at the Westminster and UMDS; students acknowledge how fortunate they are to learn Anatomy from him. Mr David Eames is the Registrar of the University of London, Mr Musselwhite is the Secretary of UMDS and Mr Baker is our Registrar and you will hear him shortly.

'Everyone is proud of our new graduates, not least the parents...and I understand the sacrifices you have to make to ensure their success'

Everyone is proud of our new graduates, not least the parents and families concerned. I know what sacrifices you have to make to ensure their success. On behalf of our graduates and of UMDS I would thank you. May I also congratulate them. The medical course is not easy and today is the culmination of five or six years' hard work, particularly I suspect in the last few weeks. However, as well as the work, I do hope everyone has enjoyed their time at UMDS and will carry fond memories of this time throughout their professional careers. This year 10% of

our graduates achieved Distinctions and they deserve special congratulations. Sadly 4% of the candidates failed, and although this is less than previous years, this is of little consolation to them. We must all encourage them. Many successful doctors have failed their finals the first time round.

'Many successful doctors have failed their finals the first time round.'

I am glad to report that UMDS continues to be successful and to expand. We now employ over 1700 people and our budget for next year will exceed £70 million. Our grant income continues to rise and last year amounted to nearly £24 million. Since its formation fourteen years ago, UMDS has grown into a major research organisation, both basic and applied, and in addition it has extended its activities to postgraduate education. We have over 1,000 medical students, nearly 500 dental students, and last year 116 students undertook an intercalated BSc. In addition to our undergraduate students, we have 379 taught postgraduate students undertaking Master of Science degrees and diploma studies, and 376 people are undertaking research training for degrees as Masters or Doctors of Philosophy.

The last year has been dominated once again by discussions with Kings College. London and Kings College School of Medicine and Dentistry, regarding amalgamation. The business plan to locate medical and dental education and part of the School of Nursing for the new combined institution on the Guy's site was finally approved. The new buildings being planned at Guy's will cost over 70 million and involve the demolition of Hunts House and its replacement with a science block costing over 40 million. The medical school, Shepherd's House and the Nursing School will be refurbished to provide modern research laboratories and teaching facilities. These plans do not impinge on the facilities of Guy's Hospital to the east of Great Maze Road. The opportunity to bring together research groups from King's and UMDS in modern facilities is exciting and the new teaching facilities will be welcome. I am particularly enthused by the opportunities to integrate, where appropriate, the education of

The new building being planned at Guy's will cost over 70 million and involve the demolition of Hunts House.'

doctors, nurses, and other health professionals. At the end of last year the government determined that rather than proceed with the approved business plan, the scheme needed to be tested through the private finance initiative. We hope that later this year a final decision will be reached. Nonetheless, the merger remains contingent on the achievement of this site strategy.

'This year a twinning arrangment was agreed with the University of West Indies and we intend to established a Centre for Caribbean Medicine in South London.'

We have continued to develop our relationships with similar institutions around the world. This year a twinning arrangement was agreed with the University of the West Indies, and its conjunction with King's we intend to establish a Centre for Caribbean Medicine in South London. This is an important initiative to encourage research into diseases prevalent in the Caribbean population and also in how to provide for their health needs. We also hope that visits from the faculty and students from the University of the West Indies will serve as role models to encourage young people in our own Caribbean community to consider medicine and the health professions as a career. As far as their students are conserved, we are particularly anxious that they should visit us during the summer so they can augment our cricket team!

'Johns Hopkins School of Medicine in Baltimore celebrated its 50th anniversary'

A fortnight ago our longest and closest association with the Johns Hopkins School of Medicine in Baltimore celebrated its 50th anniversary with a scientific meeting on Molecular Medicine, held at Guys and St Thomas'.

Notwithstanding our activities in research and graduate education and our plans for the future, our responsibility for the education and welfare of our undergraduate students are our main responsibilities and preoccupation. Major changes have taken place in the undergraduates curriculum over the last few years and this year's graduates are the first to qualify under this new programme. The syllabus for the basic science subjects has been integrated, Pathology has been moved to the end of the third year and final examinations

in Obstetrics and Paediatrics have taken place at the end of the fourth year. This year we had a completely new final examination on the principles and practices of medicine, rather than the separate subjects being examined individually. I would like to thank both my colleagues on the staff and the students for their forbearance in coping with these changes. Perhaps most pleasing of all one external examiner commented that he was very impressed by the warmth, humanity and humour of our students and he intended to return to his ancient university and tell his own students about them. We told him you are even nicer, though that is hardly possible, when you are not taking exams!

'Perhaps most pleasing of all one external examiner commented that he was very impressed by the warmth, humanity and humour of our students'

All the changes to the curriculum are in line with the advice of our regulating body, the General Medical Council. However, more changes are necessary and are planned. Concern over the quality and content of medical education is not new. In 1877, Sir Thomas Huxley commented, 'A system of education that favours the crammer and the grinder is a disgrace.' The Dean of Harvard, Dr Edsall in 1920 told the new doctors at their graduation ceremony that half of what they had been taught was wrong, but unfortunately he did not know which half. There is still an element of truth in that today, though with the explosion of knowledge in Molecular Science and Cell Biology and in Epidemiology we know much more about the causes of disease and dysfunction.

'A system of education that favours the crammer and the grinder is a disgrace.'

The expansion of knowledge poses constant problems for those responsible for determining what should be included in the curriculum. Whilst an understanding of biomedical science is the foundation of safe, clinical practice, it is not enough. Doctors deal with people and they need to understand them, be able to communicate with them and care for and about them. It is these aspects of medical education that currently cause most concern. It is vital that we leave enough time during the five of six years of medical education for people to

develop as human beings and to engage in activities outside medicine. Recent research from Australia suggests that doctors who perform best, at least in the early years of qualification, are those with a background in the humanities as well as in science. One of the attractions of being part of a multi-faculty university is the opportunity to provide a broader social and educational experience. Most of a doctor's work is concerned within solving the patient's problems. We hope to encourage the acquisition of this skill by developing problem solving exercises and opportunities for self learning in the curriculum. Finally, and remembering Dean Edsall of Harvard, a degree of scepticism but not cynicism is helpful. That remarkable doctor, Petr Skrabanek, who sadly died last year, defined a new disease which he termed 'scepticaemia'. He said it was an uncommon generalised disorder to which medical education was likely to confer lifelong immunity.

'Scepticaemia'- an uncommon generalised disorder to which medical education was likely to confer lifelong immunity'

One innovation which you will have noticed this year is that we have printed in the programme for today's ceremony the guidance from the General Medical Council on the duties of a doctor. It is of course the General Medical Council which regulates the profession in the United Kingdom. At some schools of medicine in this country the new graduates affirm an oath concerning the standards to which they will adhere during their professional careers. Traditionally this is the Hippocratic Oath, though parts of it, such as the portion concerning the need to look after their teachers and their teachers' families are less relevant now than perhaps they were in Greece in 400 BC. Other schools use the Declaration of Geneva, though again not everyone feels entirely comfortable with all of it. I did write to all today's graduates asking whether they would like to include a public affirmation as part of today's ceremony. I suspect that

'At some schools of medicine in this country the new graduates affirm an oath concerning the standards to which they will adhere during their professional careers.'

most were more concerned with their final exams, than with worrying about such matters because very few replied and a majority of those who did were against such an initiative. Nonetheless, it seems appropriate that all of us should constantly be aware of the duties that we have to our patients.

I would like to end by saying two very special thank yous. The first is to Lord Butterfield, as Chairman of our Council of Governors. He is one of the most talented and distinguished doctors of his generation and I have benefitted enormously throughout my career from his teaching and his advice. This has been particularly the case over the last seven years and we are all immensely grateful to him. Next, I would like to thank my colleague and friend Ian Phillips, who is retiring as Clinical Dean and as Professor of Microbiology at UMDS. Both he and the department that he has led have for many years provided an example of commitment to excellence in clinical care, in teaching and in research. Most recently, we have benefitted hugely from his work with our clinical students and we are all extremely grateful to him.

'No one who is involved with the National Health Service, with teaching and with research can afford to feel complacent in today's world.'

No one who is involved with the National Health Service, with teaching and with research can afford to feel complacent in today's world. Nonetheless, and in spite of the difficulties and controversies that we have faced over the last few years, I believe that UMDS is a successful and happy organisation and that this is so due to the commitment of its staff and its students. To both I would like to express my appreciation, and ask our new doctors to remember throughout their careers that one day, if not already, they too will be patients.

Thank you.

C. CHANTLER
Principal

GUY'S & ST THOMAS' HOSPITAL TRUST

Guy's Hospital
Biennial Dinner

FRIDAY 4TH OCTOBER

7pm for 7.30 pm

THE NEW CONNAUGHT ROOMS,

GREAT QUEEN STREET, LONDON WC2B 5DA

Can I take this opportunity to remind all readers of the Gazette that the 1996 Biennial Dinner will be held on 4th October, traditionally the first Friday in October.

All graduates of Guy's Hospital Medical and Dental Schools, all graduates of UMDS, and the medical and dental consultant staff of the Guy's and St Thomas' Hospital Trust are welcome to attend.

For tickets (price £40 each), please contact:
Mrs Barbara Ingarfield in the Medical Director's Office,
Counting House, Guy's Hospital, on:
Tel: 0171-955-4169
Fax: 0171-955-4824

Martin Jourdan
Honorary Secretary

August 1996

Practical Medical Microbiology.

This book weighs 2.1 kilograms and costs £95.00. On no account should any UMDS medical student buy or even read it in the hope that it will help them in their endeavours to pass the Pathology examination. It won't.

That is not to say it contains nothing of value, for herein are detailed all the arcane mysteries of what actually happens in the swirling odoriferous depths of the microbiology laboratory. How we actually give a name (which you can neither understand nor pronounce) to the blobs on the agar plate; believe it or not science is involved. How we tell what antibiotics might be useful against a given germ and how to do it all safely. Recipes for media, in or on which to grow the bugs, include "horse flesh digest broth" good for cultivating a luxuriant growth of haemolytic streptococci - first take 900 grams of horse flesh ..... Or how about some "Robertson's cooked meat broth" (good for anaerobes)? Take 500 grams of fresh bullock heart... You never knew microbiology could be so appetising.

Over the years at UMDS your teachers have steadily expurgated from our courses the minutiae of the procedures that take place in the microbiology laboratory to provide doctors with the relevant information about the microbes afflicting their patients. We are training doctors not laboratory personnel. The book is a perfectly acceptable laboratory technical manual for the use at the bench in a clinical laboratory. It has a long pedigree and is now in its fourteenth edition but the format is dull and there is not a single colour picture to break the monotony of thirty poor quality black and white illustrations. After all microbiology is nothing if not colourful. But the free review copy will look good on my shelf and there it will probably stay.

Practical Medical Microbiology. Ed. J G Collee, A G Fraser, B P Marmion, A Simmons. ISBN 0443 047219.

W. R. Gransden

SPITTING IMAGE

Attending recently at a meeting of nurses, concerned about security in community setting waiting areas - once this subject had been well aired - there was a certain stillness, until one colleague questioned the wording of notices. Then another suggested that, apart from warning their clients about behaviour likely to cause a breach of the security system, might it be possible to have notices advising 'no spitting'?

TB is ion the increase, and she claimed, spitting had a lot to do with this. One waiting area allegedly recently entertained a patient with open TB, and another patient waiting nearby had caught this disease; this was the only known contact. Dried sputum it had been hinted, could be a source, whereby the tubercle bacilli might become airborne.

The dangers of coughs and sneezes spreading disease used to be well known, and well advertised by a series of amusing posters. 'Why do you close your eyes when you sneeze?' goes the latest billboard sign form the Bradford & Bingley; but while we may not be able to stop sneezing, we can hold a tissue of handkerchief over our mouth or nose to prevent the spread of water infected droplets. But spitting; that is another matter. Have you noticed how common it is for young people to spit, in public, these days? At one time buses and trams used to display notices 'spitting prohibited', and a fine listed; now it is only the infamous smoker who gets into trouble!

Spitting comes in various forms. There is the old man spitting, because he has to. But a lot of contemporary spitting is a gesture. Like Sinclair Lewis's eponymous 'Babbitt', who, 'stood on the wharf before the camphotel, spat heroically into the delicate and shivering water, while the pines rustled...', so many spit today just to assert themselves.

I'm not in the habit of watching much TV, and even less sport on TV. However, I'm told sportsmen and women are the role models for the young. I'm also told that they spit a lot.

In the short space of a few minutes at a busy road junction I was amazed at the number of young men, yes they were all male, just spitting onto the road or pavement; either out of some pride to see how far they could spit, or some disgust with the world around them. Or so it seemed to me.

So spitting has become popular again, concurrent with the rise of TB. Koch may have expostulated, but perhaps my nursing colleague who demands notices prohibiting spitting is correct! We may see a decline of TB if this was drawn to the attention of the spitting public.

TB has altered its image. It now exists in resistant forms to old treatments, and is often an opportunistic infection amongst those who are im-

munocompromised. It is still most evident within parts of the community where there are poor and undernourished people.

But whatever the reasons for the rise of TB, it remains clear that spitting may be implicated in the spread of a number of diseases.

If nurses can encourage an improvement in public health, then their voices need to be heard. Hopefully, this will lead to increased awareness about hygiene - a word often more evident by its absence these days - and even regarded by some as a little old-fashioned.

Spitting images must be made to note that professional nurses are concerned about the welfare of the community, however much of the emphasis is placed on the rights of the individual these days. The greater number must not be held to ransom by the few; holistic approaches must become wholistic!

Denis Cobell

Dr. Thomas Patrick Binns

Thomas Patrick Binns LRCP MRCS DPH died on the 7th May 1996 in Middlesbrough hospital after a short illness aged 87. He qualified at Guy's in 1932, following house jobs in Chesterfield he married Ada Grant and left for the Falkland Islands.

He spent two years as a general physician based at Fox Bay on the Western Island. His practice there involved travelling to many scattered sheep farming communities on horseback. Some of these trips took several hours and he used to say that they changed the horses every four hours but not the riders.

Following this he returned to England and tried general practice in Liverpool but did not find this satisfying. He joined the Indian Medical Service in 1937. He was on active service in the Middle East for two years and promoted to the rank of Major. He became ill on active service and returned to India to join his family.

In 1942 he volunteered to go to Kashgar as vice Council-general and doctor. This involved a six week horse trek through the Himalayas to Chinese Turkistan. He was accompanied by his wife and two children.

He returned to England in December 1946 at the time India was attaining independence. The following year he joined the Colonial Service again and spent the next ten years in Northern Nigeria where he attained the senior position of Assistant Director of Medical Services. During this time he took and passed the DPH.

When Nigeria became independent, he returned to England. After working as the Medical Officer of Health in Eston near Middlesborough for two years, he became a schools medical officer in the West Riding of Yorkshire and lived in Saltburn by the sea until his death. He retired in 1983.

It was in Saltburn that he was able to spend time on his second love which was playing and teaching children to play the flute. During the last twenty five years of his life several evenings of every week were devoted to this, for which he never expected or accepted payment. His wife Ada died in 1972 but he continued with the flute lessons right up to his death.

During his long and varied medical career he always said that the training he received at Guy's had prepared him extremely well. He could not remember one occasion when he did not have some knowledge of a medical problem that he was faced with.

He leaves a daughter in Scotland, a son in Canada, who is a Guy's man, six grandchildren and ten great-grandchildren.

B A O Binns

Mrs Jean HOLE (nee Vaughan)

Jean HOLE died on 15 May 1996 following a long illness. She was born on 25 February 1924 and spent her childhood in Wales, the country of her forbears, for which she developed a lifelong love.

She started nursing at Guy's in 1943 and later became part of the team of talented staff nurses working in the operating theatres. She took part in the historic occasion on the 14th September 1947 when Professor Alfred Blalock from the John Hopkins Hospital performed the Blalock-Taussig shunt operation of subclavian-pulmonary anastomosis for Fallot's tetralogy for the first time in this country, with Lord Brock (then Mr) assisting. Subsequently, Brock abandoned this procedure and carried out direct operations on the heart, relieving the out-flow obstruction of the right ventricle by pulmonary valvotomy or by infundibular resection. During the same period he was performing mitral valvotomy on patients with mitral stenosis and, as most of the early patients had advanced disease, the operation could be hazardous and the atmosphere in the theatre somewhat fraught.

Jean Vaughan, with her technical excellence and delightful personality, was a welcome presence at such times. Subsequently, she was promoted to Sister at the time Dorothy Wilson (nee Smith) retired as Theatre Superintendent. At that time she met and married Cameron Hole who was the Resident Dental House Officer. She was a devoted mother to her three children (Alison, Shana and John) and later became an adoring grandmother to three grandchil-

dren. She suffered for many years with rheumatoid arthritis, bearing this painful disease with great fortitude. She eventually became immobile and her greatest trial then was the loss of her own independence for she was used to giving help to others rather than receiving it, and this coloured the whole aspect of her later life.

Shana Hole, George Scott

Bowyer A Qualified from Guy's in1957. Died in Devon on 27th April 1996, at the age of 65.

Halamandres A MRCS LRCP LDS RCS. Died June 27th 1996 at Oshawa General Hospital, Ontario, Canada.

Harrison CW LDS RCS. Qualified 1930. Practised in Slough, retired to Conneticut USA. Died March 31st, 1996. Will be greatly missed by his wife, Dorothy, and his three children.

Stoddart G ex-Guy's consultant. Graduated from Guy's 1941. Died suddenly after a short illness on July 6th 1996.

Oakenfull BGP FRCA Died aged 75 on March 19th 1996. Qualified from Guy's Hospital in 1944. Became a consultant anaethetist at Scunthorpe General Hospital in February 1952. Remained there until retirment in June 1985. He had many interets and was always an avid reader of the Guy's Gazette and liked to keep up with the Guy's

Vale AT (Tom) LDS RCS 1940. Died 21st December 1995. Suddenly in Overstrand, Norfolk.

Webb, Robert A J MBBS MDH (Johns Hopkins) DPM (Sydney). Died March 28th 1996 at Burradoo NSW (late of Henley, NSW) aged 73. He leaves a wife, Celia, four children and five grandchildren.

Rugby

GUY'S RFC REUNION WEEK-END April 20-21 1996

The weekend started on Friday evening for many but a pleasing crowd was evident for the first Guy's open sevens competition and the final of the ladies' United Hospitals Cup. There was a glut of outstanding rugby and the day was superbly organised. The Guy's ladies triumphed, setting the festive atmosphere for the remainder of the weekend. The sevens games were under way soon after. Organised and compered throughout by Pat Gush, several Guy's and visiting teams competed in a knockout for the winner's trophy. The touchline crowd provided a humorous commentary throughout the day. Fuller accounts of the ladies final and the sevens competition will be published separately.

The evening dinner was held in the Robens Suite. A good crowd attended many having been coerced into buying tickets by Dr. Gibson who was seen prowling the touchline during the sevens games, cajoling players with the promise of a fine evening. So it proved. There was excellent food and banter and although the speeches were as lame as usual, few could remember the details by the next morning.

The usual twin past v present games took place. The sun still shone and the pitch seemed to become harder as the games proceeded.

Before the games, all four sides gathered for two minutes silence in remembrance of Eric Dann. The Guy's flag hung at half mast over the club house.

In the first fifteen minutes the past side had little answer for the pace of the present team. Jefferies, Challacombe and Davis secured a lot of loose possession. Rosier and Ekeowa constantly threatened to run around their opposition and despite gallant performances from Ryan, Llewellyn, Jones and the other past players, the final score was the unusual margin of 52-17 to the present. Tries went to O'Sullivan, Lawton, Sharp, Gibbons, Rosier and Ekeowa. For the past, scores were achieved by Thomason, Skyrme and Lewis.

The second fifteen competition was a closer contest but the present side edged ahead to win 29-27. There was little to choose between the sides, the past using their experienced forwards to take up field, the present playing the ball wide to their backs whenever possession was gained. For the past, tries were scored by Jones, Gibson, Chew and Brazier and for the present by Morgan, Wood, Behn and Bod.

Both past sides suffered a disproportionate number of injuries, reflecting the age differential as much as their determination. There was a deflected

nose, a concussion and a pneumothorax. Stiff limbs and injuries were soon forgotten over drinks in the bar. An excellent buffet supper concluded a superb weekend.

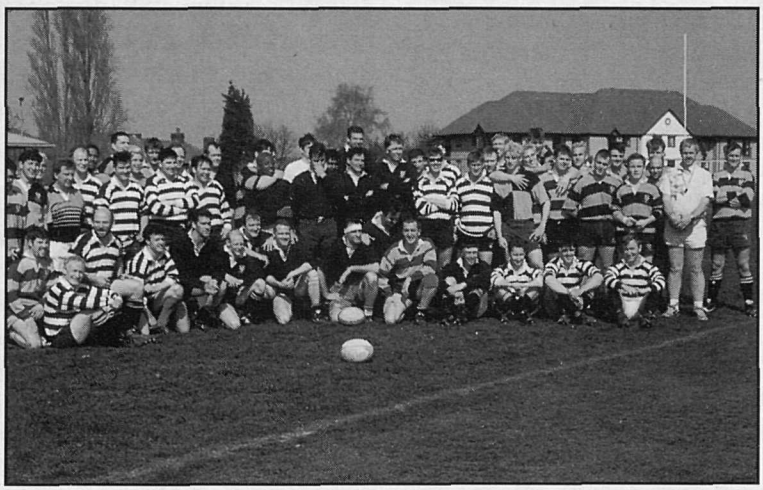
Teams:

Past 1st fifteen: A. Mistlin, C. Beardmore, J. Boothroyd, D, Balatasavaran, J. Coombes, G. Thomasson, A Jones, K. Ivil, W. Llewellyn, G. Ryan, A.Wilson, P.Gush, R. Docker, A. Skyrme, A. Hall, G. Bevan.

Past 2nd fifteen: C.Howell, T. Gibson, H. Evans, A. Bolas, K. Conchie, P. Davis, R. Bowskill, J. Brazier, H. Jones, K. Lewis, C. Stirling, T. Bryant, C. Barry, D. Gibson, P. Chew, M. Vesey, M. Danford

Present 1st fifteen: L. Hostert, F. O'Sullivan, R. Clinton, B. Challacombe, E. Barrio, P. Davis, M.Sharp, A. Jefferies, J. Davies, J. Murphy, N. Gibbons, U. Ekeowa, S. Rosier, M. Jenkins, G. Lawton.

Present 2nd fifteen: D. Francis, M. Edmundson, A. Williams, B. Wood, Bod, G. Barwell, M. Walkden, T. Edwards, Lunn, S. Darwish, P. Morgan, S. Redding, D. Jones, E. Behn, J. Harris, G. Wainsborough.



Cricket

27th April, Queen's College Oxford. Won by 4 runs.

The annual pre-season jaunt down to Oxford began at Guy's bar on the Friday night, if Talwar had his way it would have ended there to! The evening saw the initiations of all the tour virgins and the mandatory curry. The head count in the morning revealed all present bar one.....the skipper. Having stunned the Queen's bar with his juniper downing the cricket match was really a non-starter for Mike.

The game itself was close, the lads scored their first success in Oxford in years. UMDS scored a respectable 166 thanks to Talwar 34, Simcock 30 and a late blast of 35 from Marshall (Springs). The bowling and fielding was excellent and Queens were always struggling to keep up with the run rate.

28th April, King's College London. BUSA. Won by 3 wickets.

The following day saw UMDS take on a confident, strong King's side. An enthusiastic, aggressive fielding display saw King's bowled out for 134. first team virgin Behn and the new stream lined Iddawala bowled a tight opening spell and were well backed up by Mistry's variation and Sahai's off spin who finished with 4-34. On a wicket which was a nightmare for batsmen, UMDS slumped to 19 for 3 and 134 looked a large score. New boy Fitton, 20 lifted the gloom but fell just before tea leaving UMDS 59 for 5. However a match winning 32 not out from Behn with some great support from the lower order saw UMDS achieve a most satisfying win against the 'hole in the Strand.'

5th May, Kingston University. BUSA. Won by 55 runs.

Having had a walk over against QMWC a win at Kingston would mean UMDS qualify for the national stages of the BUSA competition. Once again the upper order batsmen failed to deliver and UMDS were 60 for 5, with only Jacoby 21 and Talwar 40 delivering. But once again the depth of batting and determination from the team saw UMDS crawl to 135. To defend such a low total meant the fielding and bowling had to be excellent, and with the team fired up Kingston were blasted out for 80, with Mistry getting 4-25 and Behn 3-11. A mention has to made of Fitton's splendid one handed catch to dismiss King-

ston's Middlesex schoolboy, their main threat.

8th May, Roehampton Institute. BUSA. Won by 2 runs.

On a park pitch which resembled a minefield and an outfield akin to a rugby pitch UMDS did well to amass 189. A splendid opening partnership of 89 by Jacoby 43 and Behn 47 with some quick runs at the end by Gossage 35 set up the challenging total. Iddewala 3-36 and Behn again bowled a good opening spell, but the game could have gone either way all the way up to the last over. Needing 5 runs to win off the final over with two wickets standing Behn produced the magic taking both wickets, finishing with 3-16.

12th May, Temple Sheen Eccentrics. Lost by 2 wickets.

Without seven regular first team players this was always going to be a difficult game to win. It was made more difficult by the fact only 3 players reached double figures, Jacoby 33 and Behn 21 continuing their recent good form and the return to form of Mistry 31. UMDS made a very poor 111 all out. However once again the bowling and the fielding almost won the game for UMDS. Temple scraped their way to 112 for 8 with Mistry getting the first five wicket haul of the season, 5-46.

15th May, St. George's Hospital. UL Cup 1st Round. Won by 12 runs.

A win was a must, as due to fixture clashes UMDS were unable to take further part in the BUSA competition. St George's winners of the UCH Cup three years running had a very strong side with several UCH and UL players, so beating them was a great achievement, and victory was much to do with the new never say die attitude in the field and the great team spirit. Once again UMDS had a batting collapse, the score at 9 for 3 when Misty and Behn came to the wicket. With some sensible batting they put on 65 with Behn consistent as ever scoring 32 and Mistry 54 getting the first fifty of the season. This set up the final ten overs nicely for the rest of the team to accelerate the score. Devraj duly obliged, blasting 29 from only twenty one balls, as George's fell apart in the last seven overs conceding 49 runs.

UMDS went onto the field on a high, 160 being a very respectable score on a difficult wicket after being 9 for 3. Iddawala and Behn bowled consistently

tight as usual and early wickets sent UMDS on their way with a splendid catch by Devraj at square leg. George's battled their way to their target but good tight fielding and well timed wickets saw the match evenly poised at the half way stage.

Subsequent overs saw George's as favourites to win as the usually solid fielding went slightly off the boil. It was now a case of who wanted it more. Behn returned in the now fading light and bowled a miserly spell and taking a crucial wicket. Devraj responded from the other end with an equally tight spell and a couple of wickets and UMDS had a clear chance of winning. The chance was taken with Fitton and the dependable Iddawala polishing off the tail in what was a close tense finish. Needless to say the Cobham bar saw a few beers and juniper juice being consumed.

To finish off a very satisfying day the UMDS seconds came back with an 80 run trouncing of George's seconds.

D Mistry

With these books your exams won't just be a shot in the dark.

Hit your target every time

with W.B. Saunders Company Ltd.

Tel: 0181 300 3322 **ORDER NOW!** *E-Mail:* cservice@hbuk.co.uk

For a copy of our 1996 Undergraduate Catalogue write to:
Marketing Dept, W.B. Saunders Company Ltd, 24-28 Oval Road, London NW1 7DX

CK796

FINAL MB BS EXAMINATIONS PART 7 (CLINICAL PRACTICE)

June 1996 Pass List

ABRAHAM, Sonya Marie
AFAQ, Mazhar Ahmed
AHMAD, Shahnaz
AKIRI, Andrew Obaro
ALAM, Naaz Afrina
ALBERT, Anna Maya
ALLAM, Marina
ALLEN, Giles Matthew
ALVARES, Caroline Lilian
ANDREWS, Vasanth
ANTHONY, Nathan John
AP GWILYM, Elen Rhiannon Mair Prys
BASHIR, Iqbal
BETHAPUDY, Susheel Rao
BHANDARY, Umanath Vasanth
BHAT, Yogesh
BHATIA, Anu
BHATNAGAR, Pooja
BOND, Amanda Kirsty
BROWN, James Richard Issard
BRUCE, Joanna Mary
CAHALIN, Paul Andrew
CANTWELL, Bernadette Mary
CAPOOR, Ujvala
CARPENTER, John Paul
CHANDOK, Harbikramjit Singh
CHANDRA, Aninda
CHEN, Chi Hoong Timothy Michael
CHONG, Alena Yu-Lene
CHOWDHURY, Mohua
CHUA, Wei Mei
CLAXTON, Richard Peter Robert
CLEAVER, Neil
COLE, Cordelia Joy
COLQUHOUN, Katherine Barbara Margaret
COPSON, Ellen Roxane
COSTA-MICHAEL, Michael
CROWSON, Richard Alastair
CURTIS, James
DAVIES, Christopher Julian Waide
DOVEY, Julie Karen
DOWNEY, Rebecca Juliette Brodie
DURVE, Dipalee Vijay
EDDY, Benjamin Andrew
ENVER, Mohamed Khalid
EVANS, Philippa Jayne
FERNANDES, Doreen Ann
FITZWILLIAMS, Benjamin Charles Alan Lloyd
FLYNN, Gordon Murray
FOWLER, Alison Jane
GALLAGHER, James Ronan
GANDHE, Advait Jayant
GAUTAMA, Ajay
GILL, Vippendeep Singh
GRADILLAS GONZALEZ, Vicente
GUHA, Indra Neil
HARPER, Debra Anne
HARRISON, Neil Andrew
HATRICK, Robert Ian
HETTIARACHCHI, Kapila Dharmapriyage Manisha
HOTHI, Daljit Kaur

HOYLE, Andrew
HUSSAIN, Saniya Marriam
IRWIN, Angela Ida
ISLAM, Mohammed Niazul
JAMES, Carol
JENNINGS, Jason Mark
JEYARATNAM, Dakshika
JONES, Robin Lewis
JOWETT, Andrew James Lund
KABIR, Alamgir Mahmud Nasimul
KAMVARI MOGHADDAM, Anahita
KARIM, Amin
KAZMI, Farhat Ali
KHAN, Hamed Noor
KHAN, Sameer
KIAN, Kaveh
KOCHHAR, Mohanjit Singh
KWAN, James Wei Yung
LAM, Francis Hin Tseuk
LITTLEWOOD, Richard Keith
LIVINGSTON, Stuart
LLEWELLYN, Felicity Jane
MALIK, Farida Asifa
MARSDEN-WILLIAMS, Joanna Louise
MARSHALL, Robert William
MAVRIDES, Andreas
MAYOR, Vanessa Janice
MCINTYRE, James Duncan
MEHTA, Roopa Pravin
MELIKIAN, Narbeh
MEYERS, Jessica Lucy Caroline
MISBAHUDDIN, Anjum Taban
MOORE, Harriet Louise
MORGAN, Camilla Rebecca
MORGAN, Jonathan Paul
MORTON, James Alexander Burn
MULLER-POLLARD, Christopher Sutherland
NARVANI, Amir Ali
NG, Julia Mae-Zsianne
NICOPOULLOS, James Demetri Marios
NORMAN, Charles William
NORMAN-NOTT, Arabella Gabriella
O'REILLY, Fingal Erik
OLAKANPO, Olusoji
ONG, Juling
OOI, Lai Hock
PAL, Cauvery
PAPPIN, Catherine Jane Eileen
PARKINSON, Emma Jane
PASAPULA, Chandra Seker
PATEL, Dharmesh
PATHAK, Smriti
PAY, Charlotte Louise
PEARSON, Ian Christopher
PRIOR, Kate Rebecca Edna Jane
QURESHI, Nagmi Riaz
RAVENSCROFT, Sarah Jane
REES, Angela Lynn
ROBINSON, Graham Robert Edward
RODGERS, Justin Fraser
RUST, Philippa Ann
SABIR, Nadeem Murtaza
SANTOS, Joseph Pele Dos
SAVAGE, Julian Richard
SERJEANT, Jonathan Christopher Challis
SHARIF, Saba
SHAW, Julia Clare
SHAW, Stuart Lawson
SHEIKH, Iram Safia
SHERGILL, Bhavneet Singh
SHOTBOLT, John Paul

SMAILES, Catherine Mary
SMITH, Elizabeth Robin
SMITH, Mark Charles
STARCK, Alan Lee
STOTT, Philip Martin
SUCKLING, Rebecca Jo
TENNANT, Rachel Caroline
THOMAS, Gavin David
THOMAS, Susanna Clare
UDDIN, Shahana
VARMA, Sanjay
WAN, Ka Ming Bettina
WEE, Christine Eng Lin
WELLS, Timothy Alastair
WICKREMASINGHE, Sanjeewa Sudarshan
WOOL, Pia-Sophie
YASSIN, Richard James

Assistance with accounting and tax

Responsibility for being up to date with your financial affairs is more critical than ever today.

Opportunities for maximising financial benefits for you, your family and your business are some of the advantages of taking professional advice.

For all your accounting and tax concerns contact:

Mr C J Lallemand
ACA, ATII, BSc (For)
Tel/fax 01252 725240

80 Tilford Road, Farnham,
Surrey
GU9 8DW

Experienced in accounting & tax issues relating to business, employment and financial planning for medical staff.

Neil Wilson '95.

Changing Your Address?

Please give us SIX WEEKS' NOTICE of your move. This will help us to make sure your *Gazettes* continue to reach you.

PRINT YOUR NAME AND **OLD** ADDRESS	NAME	
	OLD ADDRESS	
	TEL.	POSTCODE
THEN PRINT YOUR NAME AND **NEW** ADDRESS HERE	NAME	
	NEW ADDRESS	
	TEL.	POSTCODE

Now cut out this coupon and send to:

Guy's Hospital Gazette
Boland House
Guy's Hospital
London Bridge
London SE1 9RT

GUY'S

HOSPITAL GAZETTE

UMDS GUY'S

November/December 1996

- 40 Years of Human Chromosomes
- A Christmas Take In
- Edward Cock

UMDS Guy's Hospital Dental School

Dental Society Clinical Day

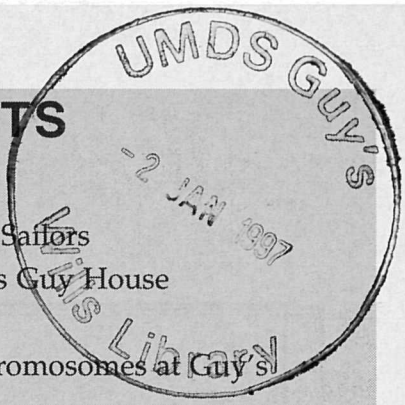
on Saturday 1st March 1997

This year's programme starts at 9.30am with the Herbert Memorial Lecture given by Professor Richard Palmer, Professor of Periodontology & Implant Dentistry, entitled "TEETH OR TITANIUM".

The lecture is followed by a series of trade, staff and alumni demonstrations, covering all aspects of clinical dentistry and current research.

The final lecture at 12.35pm, given by Professor Stephen Challacombe is entitled "Cases You Have Referred!".

Further enquiries, please contact MR L A USISKIN, DENTAL SUB-DEAN, MEDICAL SCHOOL, GUY'S HOSPITAL, LONDON SE1



CONTENTS

386 Passim
388 Letters—John Fry Dinner, Guy's Sailors
392 News—Student Tragedy, Thomas Guy House
395 Feature—Artic Expedition 1996
399 Feature—40 Years of Human Chromosomes at Guy's
407 Feature—A Christmas Take In
412 Feature—Edward Cock
417 Reviews—Radiography, Microbiology, Barbed Wire Doctor
419 Nursing Notes—Mind your back
422 Obituaries—Toby Thomas, Clare Vaughan
426 Sport—Women's Cricket, Rugby
432 Classifieds & Announcements

Guy's Gazette

Editor Barnaby Scholefield **Assistant Editor** Joseph Footitt
Features Editor Nabeela Ahmed **Sports Editor** Ben Challacombe
Layout Editor Paul Stevenson **Nursing Notes** Denis Cobell
Office Manager Margaret Flanders.
Acknowledgement Dean Flanders.

The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

Volume 110 Number 2461 November/December 1996
ISSN 0017–5870

Guy's Gazette, Boland House, Guy's Hospital, London SE1 9RT.
Tel (0171) 955 5000 ext 5413. All rights reserved.

Printed by Hobbs the Printers Ltd, Brunel Road, Totton, Hampshire SO40 3WX

Passim

The word 'Ebola' is enough to strike fear into any medical worker, let alone a member of public. Its appearance in the main Johannesburg Private Hospital has therefore sent shock waves through the medical profession of South Africa and the world. People have naïvely believed that because this disease has not appeared clinically in urban areas out of Zaire that it wouldn't. Now it has, scientists and doctors are naturally very worried. The world is now so easily travelled that viruses such as Ebola could start in Africa and be transmitted by air travel to every major city in days.

Britain used to believe that as an island we were safe from many diseases from Europe and the rest of the world, however even our quarantine laws are under threat. Proposals to make us loosen our countries regulations on the three months isolation period for animals, by pressure groups, could allow these diseases to return to our country.

Even in our own hospitals we our experiencing lack of control. A few months ago both Guy's and St Thomas' were put on alert after the discovery of four cases of multy resistant TB at St Thomas', just another example of how simple our medical knowledge still is when confronted by these microscopic bacteria and viruses.

What would have happened if theAfrican doctor, who was carrying the Ebola virus, had flown to Gatwick and made his way to Guy's casualty? One can't comprehend the nightmare consequences we would nave on our door step. Let's pray it doesn't happen or perhaps search for more clues to understand these diseases. Maybe even both.

Letters

We would like to hear your views on any issues raised in any of the Gazettes, or anything to do with Guy's. You may have an opinion you would like to share with the rest of the readership. We would like to see some of your points published in future issues. If you feel you want to air your thoughts, please write to the editor.

You are reminded that it is the editor's discretion whether to publish a letter and that derogatory personal references to any individual will not be acceptable. We will, however, do our best to let you have a say.

NB: Copy date for Gazette is 20th of each month

John Fry Dinner

Dear Sir,

For the past few years I have written to the Gazette about the John Fry Dinner.

It was started in 1988 by the late Dr John Fry for his fellow students of the year 1944 and now covers most of the 1940s. The 9th John Fry Dinner was held at Guy's on October 16th 1996 and, as always, proved most enjoyable. We had a record attendance of 64 Guy's men. They included Professor Alec Bearn from New York, Bill Jeanes from Toronto and Alec Graham from Zimbabwe who lowered the average age by bringing his grandson, Peter Howarth, currently a student at UMDS. Dr 'George' Houston, our guest of honour, gave some entertaing reminisences of the days at Guy's before the war when the senior physicians were all powerful. Dr Robert Knight kindly updated us about the situation today. Several people have come to the dinner as a result of reading my letters to the Gazette and this is the reason I am writing to you again. Next year's dinner will be on Monday October 13th 1997 at Guy's. Any Guy's man of the 1940s or thereabouts who think they might enjoy a bit of old aquaintance is welcome to contact me for further information.

My address is Dr R E Irvine, Dolphin House, Le Foulon, St Peter Port, Guernsey GY1 1YY. Telephone: 01481 723298 Fax: 01481 714135

Yours faithfully,

R E Irvine

Mortality

Dear Sir,

Since being a student at Guy's I have thought a lot on philosophical subjects now, as a General Practitioner I believe I have brought some precision to the question of mortality.

This is a subject increasingly discused these days, vaguely and very loosely. Here are my thoughts on the subject. The problem with 'mortality' is that it is a word vaguely used. How do we obtain the core meaing of this word? I suggest that we look at the word 'evil'. Evil, to my mind, is the giving of unnecessary pain to one individual by another. As a principal in general practice of 37 years standing, retired 12 years ago, it appeared to me that the greatest evil was to allow pain, physical or mental, to be suffered by a patient without doing anything about it, either treating the cause or giving symptomatic relief. It became rational to me that the opposite of evil was mortality, either not giving unnecessary pain to a fellow human being and the giving of relief of that pain if at all possible. Medicine is obviously a

moral profession. Rationalising via evil to mortality, it is simple to deduce the Ten Commandments. Religious faith is unnecessary in this deduction, although to those who are relgious, I would not say that the sense of what I have written above could have been implanted by God. If people lived, primarily, by the core meaning of mortality, namely the opposite of evil, the world would be a better place.'

Yours faithfully,

Norman Bloch

Guy's Sailors

Dear Sir

On Sunday 29th September, 1996 the fleet of the British Telecom Global Challenge set sail on the worlds toughest yacht race, west about against prevailing winds and currents.

Guy's men and women might like to know that among the two hundred or so crew volunteers there are three Guy's trained sailors. Henry Pritchard sails on Pause to Remember; he is a dentist who trained in the late 50s and 60s. Andrea Carter will be the 'medic' aboard 3Com and qualified SRN in 1960 (see Gazette, Nov-Dec 1995). Sally Stewart (nee Drew) is crewing as 'medic' in charge of communications on Health insured II. She trained as a nurse at Guy's, qualifying in 1970. No other teaching hospital can lay claim to three sailors in this race. Those wishing to follow their progress from the UK may tune to BBC2 on the following days:

Friday, November 22nd
(1st leg to Rio)

Friday,February 7th
(Rio - Cape Horn - New Zealand)

Friday, May 2nd
(Wellington - Sydney - Cape Town)

Friday, July 4th
(Cape Town - Boston Mass)

Friday, August 1st
(Race across the Atlantic - Southampton)

Race news and up to date mapped position and crew profile are available either on BT recorded message service 0891 505550 or via the Internet at http://www.btchallenge.com.

Guy's men and women throughout the world may like to make contact with them at the following ports. Wellington 31st December - 9th February 1997, Syndey 15th February - 2nd March 1997, Cape Town 8th April - 4th May 1997, Boston (Mass) 12th June - 29th June 1997.

The Springboks at Guy's in the late 1930s may be interested to know that Sally Stewart is the daughter of Jack Drew (34-39) who became anatomy

demonstrator at Pembury and, after the war, surgical registrar and senior registrar at Guy's. If he is spared, he will be meeting his daughter in Cape Town at the end of April.

Yours faithfully,

Keith Stewart
(Guys 64-69)

Blue Baby

Dear Sir

It was interesting to read Paul Carvlin's report on his progress after being operated on as a 'Blue Baby' in 1961 at the Evelina Children's Hospital.

When I joined Guy's as a dental student during the war years we were stationed at large houses like Sherwood Park and Rookleigh in Tunbridge Wells. The Dean was Mr T J Evans and he resided at Rookleigh and spent a lot of time with us. Later we joined the Dental School in London. During the year of 1944 there was great excitement at Guy's as an American Surgeon whose name I think was Mr Blalock had come to the hospital to instruct Mr Sammy Wass and other surgeons to perform the 'Blue Baby' operation. Surgery has advanced considerably since then . Cardiac surgery at that time was unknown as was kidney dialysis and transplants. Dentistry had also seen dramatic changes. At that time in old rows of the operating chairs. The two back rows had foot engines. More senior students moved to the anterior row of chairs which had electric dental engines (no airators) to operate. Rather like driving a Roll Royce after a mini. At that time a patient was allowed only one root filling due to adverse reactions.

Yours faithfully,

Peter Holmes.

Pioneers

Dear Sir

Your readers may like to know that Paul Carvlin (Blue Baby in Guy's Gazette, October 1996) figured in the BBC 2 TV programme 'Pioneers' on September 23rd.

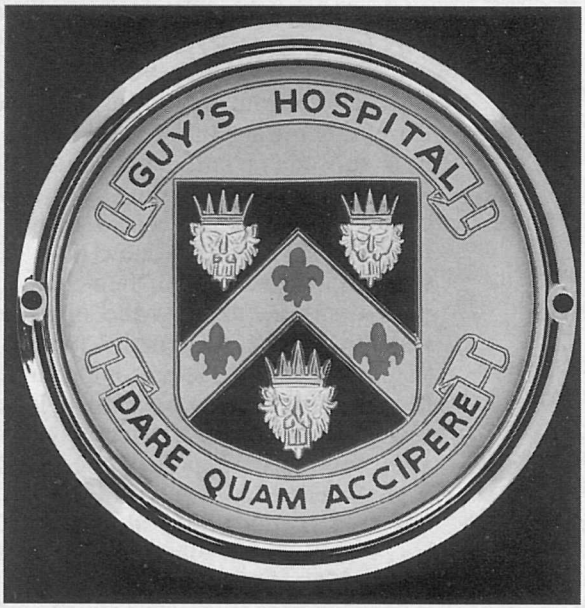
Unfortunately, this programme omitted to mention that Paul's operation was carried out at Evelina Children's Hospital in Southwark and that his preoperative stay was in Guy's Hospital where his heart problem was investigated. Furthermore, there was no acknowledgement to the Guy's and St Thomas' Trust, where filming took place. Just forgetfulness I imagine!

Many thanks,

Michael Joseph

Guy's Hospital MEMORABILIA

Unique items available only from the Gazette



Specially made, limited edition Guy's crested car badges. Grey background, black shield with silver lions, gold crowns and blue fleur-de-lis on a gold chevron. The motto is displayed on gold scrolls with black lettering. Frame forged in solid brass finished with deep chrome plate.

Price £25 each + £1 p&p

To: *The Manager*
Guy's Hospital Gazette
Boland House
St Thomas' Street
London SE1 9RT

I enclose a cheque/PO for £ .....
NAME: .....
ADDRESS: .....
.....
Tel:.....

Please make cheques payable to Guy's Hospital Gazette

Office hours: Monday to Friday 1-5 pm. Personal callers welcome.

Medical Student is Tragically Killed

On November 24th Toby Thomas, a second year medical student at Guy's and St Thomas' was tragically killed whilst cycling home along Kennington Park Road.

All the staff and students were deeply saddened at the event and the welfare officer and student counsellors were on hand to help those in need of support.

The President of the student union, Kieron Rooney was helping to organise a collection from the students in memory of Toby. This money is intended to be donated soon to a charity of his families choice.

This tragic incident highlights however the dangers that students, especially at Guy's and St Thomas' have to endure when travelling between hospitals and from home on the south London busy roads.

Increase in Subscriptions

The time has come for the Gazette to increase its annual subscriptions to £20. The Gazette has not had to increase its subscriptions now for four years, but due to higher printing and publishing costs we have unfortunately been forced to make this rise.

The editorial and management team at the Gazette hope that you feel the Guy's Gazette is still value for money and continues to supply you with news and features from Guy's Hospital. The Gazette is always on the look out for new subscibers both new graduates from Guy's and those old Guy's men and women who have drifted away from the hospital and want to get back in touch with the news of their contempories and friends. On the opposite page you will find a renewal form for your subscription. Please could you fill it in and send it to your own local branch of your bank. Thankyou for your continued support of the Guy's Hospital Gazette.

Welfare Officer

UMDS finally has a full time student welfare officer, Alison Aherne. She is based on the first floor of Boland House at Guy's and is available to all students for confidential advice on all sorts of domestic, social and educational problems.

Alison's previous job was at Queens University, Belfast where she gained vast experience working with student problems. Already at Guy's over the last term she has been over whelmed with requests for advice over a wide variety of problems ranging from rent

INCREASE IN SUBSCRIPTIONS 1997

Please send completed form to your **own bank** by December 20th 1996

To Messrs.....Bank
Address of Bank.....

With Reference to my **existing** Bankers Order Subscription made payable to "Guy's Hospital Gazette"

Please alter my current payment to £20.00*
to be paid annually commencing 1997 on the same date as previously until further notice

TO THE CREDIT OF "GUY'S HOSPITAL GAZETTE"
ACCOUNT NO 80401269 AT THE MIDLAND PLC
CODE NO. 40-06-21
SOUTHWARK BRANCH, 28 BOROUGH HIGH STREET,
LONDON SE1 1YB, AND CHARGE TO MY SAME ACCOUNT

SIGNATURE.....DATE.....
ADDRESS.....
.....
.....TEL.....
NAME (Please print) .....
ACCOUNT NO .....

*Usual discounts apply.

troubles with the landlord, to stress problems with work. She is also available if all you need is a friendly ear to listen to your problems, however minor.

Anyone wishing to see Alison can simply walk in any time between 9am and 5pm, or call Guy's ext. 8714 and make an appointment. Alison is very willing to see students outside of office hours with an appoinment.

The Gazette hopes soon to publish upto date advice by Alison on financial, educational, and residential matters which will be helpful to everyone who reads the Guy's Gazette.

Thomas Guy House

Guy's hospital has renamed its phase III building (originally Philip Harris House) on St Thomas' Street after the founder, Thomas Guy. Thomas Guy House is scheduled to be opened in the summer of 1997. The seven storey building will have 112 inpatient beds and house general and specialist out patient clinics. According to the Trust 'It will become the cornerstone of hospital care at Guy's', somewhat ironic then that the facility is opening several years late and following many changes to it's proposed use.

Simon Hughes MP pointed out at the recent Save Guy's Campaign Meeting that the building is still structurally the same as was designed originally. This means that the infrastructure remains for it to be an advanced sugical unit. It was found at the planning committee meetings where the plans were revised during the changes for both Guy's and St Thomas' hospitals that it would have been too complicated to try and change all the architecture of the building to be anything else. It is therefore keenly anticipiated as to what will happen in the Thomas Guy House if it is finally opened next summer.

Artic Expedition 1996

Guy's Student Explores Norway

A year ago I was invited to be a leader on an expedition to Svalbard, a Norwegian land mass situated 10 degrees south of the North Pole. The organisation, The British Schools Exploring Society, was to take more than 70 sixth formers from across the country on a six week scientific expedition, incorporating adventure and physical stress. I had been on two previous BSES expeditions, as a school leaver to Botswana for three months, and as an assistant leader to Zimbabwe in 1994. Thus whilst I knew much about expeditions I knew nothing of the Arctic. I was also asked to lead the Botany science, a subject about which I knew equally little.

'Thus, as the summer of 1996 approached, it was with a sense of great apprehension, and at times of impending doom, that I saw the expedition draw closer.'

Thus, as the summer of 1996 approached, it was with a sense of great apprehension, and at times of impending doom, that I saw the expedition draw closer. I read my books on Arctic plant life and indeed anything I could lay my hands on about the Svalbard archipelago. With the permission of the Dean and my Paediatric consultant, I left my paediatric firm after just two weeks, and set off on the journey of a life time. Svalbard.

'...ski-ing all day, and nearly every day, across the most beautiful glaciers in the world.'

The next six weeks were spent with 12 sixth formers and two other mountain leaders ski-ing all day, and nearly every day, across the most beautiful glaciers in the world. We spent the first seven days on the tundra and moraine doing some fascinating botany studies - the fact that plants should even live here is a testament to the wonder of nature. Small, yet beautiful flowers grew abundantly on the low lying tundra, and even high up on exposed mountain peaks and ridges. Seeds had found their way and germinated

on scree slopes that are exposed to temperatures of minus 50 degrees in winter, thick coverings of snow and howling winds. In the short summer season, they flower rapidly and produce new seeds, before hiding once again for the onslaught of winter.

'We used army Arctic rations, but with each man day of food weighing one and a half kilos, travelling for 10 days meant carrying 150 kg of food alone.'

Once up on to the glacier, we travelled daily, at first with crampons over the ice and then on to our skis across the thick snow. We worked in groups of three and carried with us all our food, our tents, our cooking stoves, our fuel, our ropes and safety equipment and of course our personal belongings. The latter was kept, understandably, to a minimum, but the climate demanded a sufficient amount of warm clothing and sleeping items. We used army Arctic rations, but with each man day of food weighing one and a half kilos, travelling for 10 days meant carrying 150 kg of food alone. We thus made dumps of food on the glacier to which we could return on our way back, and 10 days food was the most we ever had to carry. Clearly a rucksack was not going to fit all this in, and so in our threes, a pulk (a sledge) was used for all communal items. Every third day therefore entailed not only carrying your rucksack but pulling a pulk behind you with three peoples food in (max. 450kg) a tent, stove, several litres of fuel, spades, crampons, and other miscellaneous items. One group in the twelve would also be lumbered with the radio!!

'Despite our heavy loads, the skiing was wonderful. The scenery was spectacular - the vastness of every scene was incredible.'

Despite our heavy loads, the skiing was wonderful. The scenery was spectacular - the vastness of every scene was incredible. Huge blue skies, vast white glaciers, long spectacular ranges and sprangly blue fjords. The size and age of the landscape was awesome. Hard physical exercise but not a worry or care in the world made for the perfect de-stressing escapism that such expeditions offer. True happiness was a term I used regularly in my diary, and not a day passed when I did not laugh deep and heart-felt laughter. Only when one is so stress-free do you realise how stressful life is in the so - called developed West. We replace physical labour with mental

stress (little surprise that there is more mental illness here than in 'less developed' societies, but better physical health) and although I would never wish to be physically unwell, I know which state I prefer. I count myself lucky to have experienced the two very different worlds, of primitive survival against the elements, when all that matters is something to eat and drink, somewhere to rest and someone to talk with, and the complicated world we called progress.

'Six weeks in the Arctic was an infinite learning experience for me.'

Six weeks in the Arctic was an infinite learning experience for me. I learnt about the Arctic itself, its geography and geology, its plant and animal life, about mountain techniques and crevasse rescue, about other people and of course about myself. I could not begin to relate how much I have learnt, and the six weeks paediatrics I have missed in exchange can be learnt out of a book any time. I am so glad that I went.

Hannah Lord
4th year medical student UMDS.

BMA

JOIN THE BMA

or the BUCK stops with you!

- *advice on employment matters & contracts*
- *discounted schemes & advice from BMAS & BMAPS on financial and insurance matters*
- *BMJ and classified ads*
- *use of the BMA library & medline*
- ***and much more***

U M D S

Programme of Talks for 1997

13 January

'Intercalated BSc'

by Dr J H Thomas, UMDS Dean

in Nevin Lecture Theatre

12 February

'Medical Careers'

by Rosemary Weston, BMA Careers Officer

in Postgraduate Centre

27 March

'House Officer Experience'

by Dr Stella Lowry, International Dept

in Postgraduate Centre

FOOD WILL BE PROVIDED AT EACH TALK

40 years of Human Chromosomes at Guy's

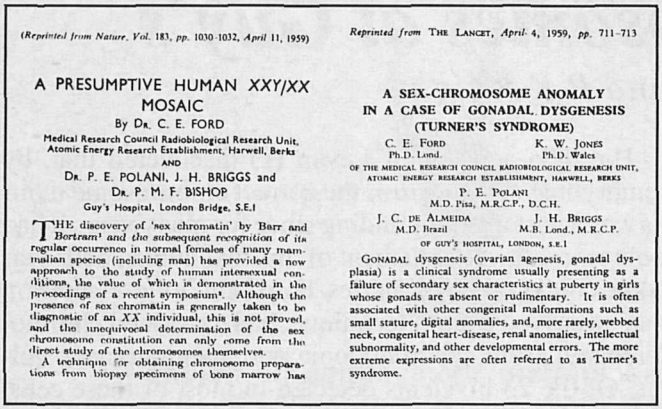
by M Adinolfi and R K Knight

Forty years ago, Hin Tjio and Albert Levan (1) discovered that, by testing human embryonic cells *in vitro,* the correct chromosome number was 46. This was an astonishing finding since for many years it had been assumed that the chromosome complement of normal human cells was 48. This result was soon confirmed by Charles Ford and John Hamerton (1956), who, by using an improved squash technique, had examined chromosomes in metaphase prepared from spermatogonia and spermatocytes collected from three males. Of the 23 bivalents detected in most of these cells, one bivalent was clearly formed by unequal X and Y chromosomes, which occasionally could also be seen unpaired.

'This array of papers on the properties and abnormalities of human chromosomes was the culmination of many years of intense, and often frustrating, investigations...'

The next few years witnessed a series of publications in The Lancet, showing that the aetiology of many syndromes could be attributed to specific chromosomal disorders. Perhaps the most rewarding year was 1959 when, in January, Pat Jacobs and John Strong (2) published the first report on the detection of a chromosome complement 47, XXY in patients with Klinefelter's syndrome, while, soon after, Lejeune, Gautier and Turpin (3) described the presence of an extra third chromosome 21 in a patient with Down's Syndrome. During the same year, two papers, in which Paul Polani was co-author, documented the first case of Turner's Syndrome, characterised by the absence of a chromosome X (45,X), and the first patients with a mosaicism XXY/XX and Klinefelter's clinical syndrome (Fig 1). Also in 1959, the first subject with three chromosomes X (47,XXX) was recorded by Pat Jacobs et al, once again in The Lancet.

This array of papers on the properties and abnormalities of human chromosomes was the culmination of many years of intense, and often frustrating, investigations, beginning in 1858, when Wirchow described cell division and showed that cells never arose *de novo*, but always from other cells. In 1882 Flemming produced one of the papers on the analysis of human chromosomes. (Fig 2) However most attempts at determining the correct human chromosomal number were unsuccessful, until, in 1923, a general consensus was reached in favour of 48 as the human diploid number (Painter 1923). These early studies were performed on histological sections of testis and by dispersion of the chromosomes with hypotonic solution. So strong was the view that 48 was the correct diploid number that Hansen-Melander (cited by Tjio and Levan, 1956) thought that the human liver was a chromosomally abnormal tissue and abandoned her work on liver fibroblasts, since she was unable to find the 47th and 48th chromosomes!.



(*Reprinted from Nature, Vol.* 183, *pp.* 1030-1032, *April* 11, 1959)

A PRESUMPTIVE HUMAN *XXY/XX* MOSAIC

By Dr. C. E. FORD

Medical Research Council Radiobiological Research Unit, Atomic Energy Research Establishment, Harwell, Berks

AND

Dr. P. E. POLANI, J. H. BRIGGS and Dr. P. M. F. BISHOP

Guy's Hospital, London Bridge, S.E.1

THE discovery of 'sex chromatin' by Barr and Bertram[1] and the subsequent recognition of its regular occurrence in normal females of many mammalian species (including man) has provided a new approach to the study of human intersexual conditions, the value of which is demonstrated in the proceedings of a recent symposium[2]. Although the presence of sex chromatin is generally taken to be diagnostic of an *XX* individual, this is not proved, and the unequivocal determination of the sex chromosome constitution can only come from the direct study of the chromosomes themselves.

A technique for obtaining chromosome preparations from biopsy specimens of bone marrow has

Reprinted from THE LANCET, *April* 4, 1959, *pp.* 711-713

A SEX-CHROMOSOME ANOMALY IN A CASE OF GONADAL DYSGENESIS (TURNER'S SYNDROME)

C. E. FORD, Ph.D. Lond. — K. W. JONES, Ph.D. Wales

OF THE MEDICAL RESEARCH COUNCIL RADIOBIOLOGICAL RESEARCH UNIT, ATOMIC ENERGY RESEARCH ESTABLISHMENT, HARWELL, BERKS

P. E. POLANI, M.D. Pisa, M.R.C.P., D.C.H.

J. C. DE ALMEIDA, M.D. Brazil — J. H. BRIGGS, M.B. Lond., M.R.C.P.

OF GUY'S HOSPITAL, LONDON, S.E.1

GONADAL dysgenesis (ovarian agenesis, gonadal dysplasia) is a clinical syndrome usually presenting as a failure of secondary sex characteristics at puberty in girls whose gonads are absent or rudimentary. It is often associated with other congenital malformations such as small stature, digital anomalies, and, more rarely, webbed neck, congenital heart-disease, renal anomalies, intellectual subnormality, and other developmental errors. The more extreme expressions are often referred to as Turner's syndrome.

Figure 1. Headings of two papers published in 1959, describing the first detection of sex-chromosomes anomaly in a patient with Turner's syndrome and the first case of mosaicism

'For some time they had suspected that female patients with gonadal dysgenisis could be sex-reversed males.'

Only when a critical mass of technical improvements of the *in vitro* cultures was reached, did it become possible to analyse well spread metaphase.

Studies leading to the observation that patients with Turner's Syndrome have a chromosome complement 45.X best illustrate the difficulties encountered in untangling complex disorders characterised by a variety of symptoms. For some time Paul Polani, working with Maurice Campbell and Lord Brock on the cause of congenital heart diseases, had suspected that female patients with gonadal dysgenisis could be sex-reversed males.

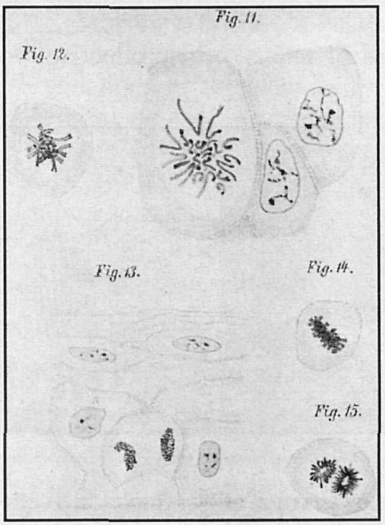


Figure 2. The earliest known rendering of human chromosomes are these drawings by W.Flemming (1882), based on observations of deviding nuclei from epithelium.

The discovery that the 'Barr Body' was present in females but not in normal males provided Polani and his colleagues at Guy's with the opportunity to see whether an abnormality of the X chromosome could be held responsible for the clinical manifestations typical of patients with Turner's syndrome. The 'sex chromatin' in mammals had been accidentally discovered in 1949 by Barr and Bertram (4) who had noticed a morphological difference between the neurones of male and female cats. A distinctive body, that they termed 'the nucleolar satellite' was visible in the nuclei of neurones from females, but not in those from male cats. This observation was rapidly extended to other species and tissues (Fig 3). Initially, Barr and his colleagues believed that the sex chromatin was derived directly from the heterochromatin regions of both X chromosomes condensed together. Only later was it shown that the Barr body results from the condensation of only one of the two X chromosomes in female subjects.

Three cases of Turner's syndrome were tested and found to be sex-chromatin negative (Polani et al. 1954). This paper, previously rejected by Nature, but later accepted by The Lancet, was soon followed by another one indirectly supporting

the hypothesis that these patients were 'XO' in view of the high incidence of red/green colour blindness, comparable to that observed in males (Polani et al 1956).(5)

This was the beginning of many years of intense and productive work on diseases due to specific chromosomal disorders. The most significant early technical development was the establishment of chromosome analysis using peripheral blood lymphocytes. Tests were economical, could be completed in about three days and the results were highly reproducible. In the late 1950s John Hamerton and Francesco Giannelli joined the Paediatric Research Unit which with the financial support of the Spastic Society, was initially divided in four sections- Cytogenetics, Epidemiology, Experimental Pathology and Biochemistry to which Immunology was added 3 years later - all working on the sound principle of combining Research with Service. Thus, while 'Service' would provide the first with 'material', the success of the research could deliver new diagnostic tools to benefit 'Service'.

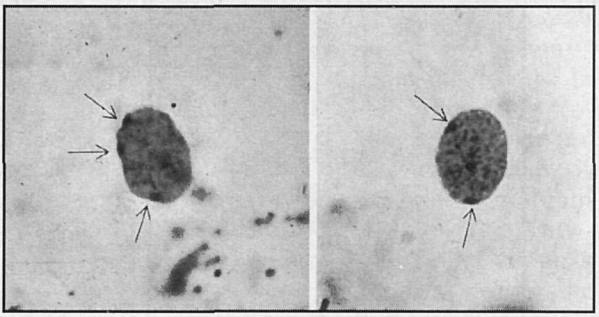


Figure 3.Detection of Bar Bodies in a cell from a female patient 47, XXX and a cell from a male patient 49, XXXXY.

The most significant early technical development was the establishment of chromosome analysis using peripheral blood lymphocytes.

During the early years, the main lines of investigations in Cytogenetics were directed towards a better understanding of the mechanisms leading to chromosomal abnormalities at meiosis, their associations with specific clinical symptoms, such as unique 'finger print' patterns, and the relationship between unique chromosome disorders (such as trisomy 21) and maternal or paternal age.

A link between maternal age and Down's syndrome had been noticed for some time, but it was not clear why, in older women, oocytes should be more prone to errors of chromosome non-disjunction. In 1968, Henderson and Edwards, as an alternative to the view that abnormal non-disjunctional chromosomes were those that, during investigations between Polani and Crolla were needed to give support to the 'Production line' or 'First in- first out' hypothesis, according to which the oocytes entering meiosis late would have fewer total chiasmata than early maturing cells and consequently would produce univalents often subjects to random non-disjunction.

'The discovery that patients 45,X were female and those with a chromosome complement 47,XXY were male clarified the hypothesis about sex differentiation.'

The discovery that patients 45,X were female and those with a chromosome complement 47,XXY were male had also a strong impact in clarifying the various hypothesis advance about sex differentiation. In fact, it became clear that the maturation of the primordial gonads into testes was not controlled by the X chromosome (e.g. two Xs = female; one X = male, as in fruit fly), but was due to the presence of gene(s) on the short arm of the Y chromosome, independently of the number of X chromosomes. Sex differentiation and the role of genes on both the X and Y chromosomes were soon the target of many lines of investigation in the Paediatric Research Unit at Guy's.

In addition to constitutional abnormalities, several disorders associated with an inherited tendency to chromosome breakage and rearrangement as well as defects of DNA repair enzymes were and are still investigated in the unit

Although, over the years, many changes have occurred in the structure of the Paediatric Research Unit - and even its name has changed to stress the molecular orientation of its research - the chromosomes, their abnormalities and their genes continue to be at the centre of many investigations and of clinical services provided by the Genetic Counselling Section.

Prenatal diagnosis - a topic of interest since early observations that some inheritable forms of Down's Syndrome were due to a translocation transmitted from an asymptomatic parent - became an intense field of studies. New cytoge-

netic tests were quickly introduced to perform prenatal analysis of chromosomal disorders using fetal amniocytes and chorionic cellular elements. During the past decade, each year about 5000 samples are analysed by members of the cytogenetic unit.

With the introduction of molecular genetics, new approaches have been developed and applied to detect chromosomal abnormalities or to map genes. For example, the fluorescent *in situ* hybridisation (FISH) technique which allows visualisation of genes or entire chromosomes, was introduce as a test for the detection of specific chromosomal disorders (see: Adinolfi and Crolla, 1994) (6). Applied to metaphase chromosomes, FISH can be exploited to detect complex rearrangements, small translocations or deletions. FISH can also be used on cells in interface, thus allowing prenatal diagnosis of major chromosomal defects in only a few hours.

'...fluorescent** in situ **hybridisation (FISH) technique which allows visualisation of genes or entire chromosomes.'

Another promising approach - developed in the unit - is that based on the polymerase chain reaction (CPR) amplification of highly polymorphic sequences specific for each chromosome. Using fluorescent primers, in a short period of time it is possible to detect the most frequent aneuploidies involving chromosomes 21,18 and 13, as well as sexing the fetuses (Pertl et al, 1996).

This brief note is not meant to be a comprehensive review of all the research carried in the field of Cytogenetics and, consequently, we regret inevitable omissions. Our aim is to highlight the many investigations on the properties and roles of chromosomes in health and disease performed over several decade here, at Guy's. For those who directly, or as spectators, have lived through this period, it has been an exciting experience.

References

1. Tjio J H Levan A (1956) The Chromosome number of man. 42 1-6

2. Jacobs P A and Strong J A (1959) A case of human intersexuality showing a possible XXY sex determining mechanism. Nature 183 302

3. Lejuene J Ceutier M and Turpin R (1956) Les chromosomes humains en culture de tissus. Comp. Rend. Acad Sci (Paris) 248 602-603

4. Barr M L and Bertram E G (1949) A morphological distinction between neurones of the male and female, and the behaviour of nuclear satellite during accelerated nucleo- protein synthesis. Nature 163 676-677

5. Polani P E, Lessof M H Bishop P M E (1956) Colour-blindness in 'ovarian agenesis' (gonadal dysplasia). Lancet ii 118-120

6. Adinolfi M and Crolla J (1994) nonisotonic *in situ* hybridisation. Clinical cytogenetics and gene mapping applications. Adv Hum. Gen 22 187-256.

Guy's Hospital
MEMORABILIA

Unique items available only from the Gazette

English Pewter Tankards and Goblets, engraved with the Guy's Crest, available only from the Gazette, individually boxed.

Price £22 + £1 p&p

ORDER FORM

Name .....
Address .....
Tel: .....
Please send me .... *Guy's Goblets at £22+£1 p&p*
.... *Guy's Tankards at £22+£1 p&p*
I enclose a remittance of £ .....

To: The Manager, Guy's Gazette Office,
Guy's Hospital, London SE1 9RT
Tel: 0171 955 5000 ext 5413

Personal Callers Welcome
Office hours: Monday to Friday. 1–5 p.m.

A Christmas Take In

Story of the Evelina Children's Hospital

Once upon a time there was a hospital. It was an odd blunted crescent of a building which stood on an odd blunted crescent of a site sliced off when the new Southwark Bridge road was realigned in the early part of the 19th century. It was here, in one of the poorest and most squalid parts of London, that Baron Ferdinand de Rothschild chose to build a permanent memorial to his unfortunate wife Evelina.

'Of course the hospital was named the Evelina Children's Hospital after the unlucky Baroness, and it opened in 1869 to care for the sick and poor children'

In 1866, only some seventeen months after her wedding, both she and her infant son had died following the premature labour brought on by a railway accident. Originally the Baron had intended to build a lying-in hospital, but was persuaded that there was a much greater need for a children's hospital. So for the sum of £10,000 he purchased that odd-shaped plot which was known, most inappropriately, as South Sea Court. A further £10,000 was allocated for the building of the hospital itself and for the first few years it was run almost entirely at the founder's own personal expense. Of course the hospital was named the Evelina Children's Hospital after the unlucky Baroness, and it opened in 1869 to care for the sick and poor children of the surrounding district. It is hard to imagine the conditions which must have existed then, but street names like Dirty Lane, Foul Lane, Harrow Dunghill and Labour-in Vain Alley give a clue. In Bleak House, Charles Dickens describes an infamous neighbouring slum called Tom-all-Alone's, '..... these ruined shelters have bred a crowd of foul existence that crawls in and out of gaps in walls and boards; and coils itself to sleep, in maggot numbers where the rain drips in; and comes and goes, fetching and carrying fever and sowing more evil in its every footprint.....'.

'..with street names like Dirty Lane, Foul Lane, Harrow Dunghill and Labour- in Vain Alley.'

In the overcrowded and insanitary conditions infant mortality was appalling and infection of all kinds rife.

Gradually, very gradually, conditions were to improve as public health measures such as clean water and drainage had their effect, but poverty, malnutrition and overcrowded slum housing continued to take a heavy toll, especially of the young. In the Second World War the Blitz demolished many of the slums, and post-war rebuilding programmes eventually cleared the remainder. Throughout all this time, lasting over a hundred years, the Evelina cared for the ill and injured local children and came to be held in the highest esteem by an entire community.

'Evelina cared for the ill and injured local children and came to be held in the highest esteem by an entire community.'

With the introduction of the National Health Service in 1948 the Evelina ceased to be an independent hospital and came under the control of Guy's. The Evelina nurses began to train in the Guy's PTS and the wards and out-patients became a common training ground for both nursing and medical students. For the latter the Children's appointment was split between the two hospitals, thus considerably increasing their clinical experience. Normally two students would share the 'take-in' week, which necessitated living at the Evelina, meals being provided in the staff dining room and a bedroom in the disused vicarage of the bombed All Hallows Church across the street from the hospital.

'I always found Christmas in hospital to be an enjoyable time (provided you were not there as a patient!)'

It so happened that one of my take-ins fell during Christmas week. The majority of fellow students quite naturally wished to be at home with family or friends and thus it was that I spent that particular week on my own. I always found Christmas in hospital to be an enjoyable time (provided you were not there as a patient!) and the decorated wards, bone-picking parties and the general happy and festive atmosphere were ample compensation. Besides which I had a girl friend at Guy's who was also on duty over Christmas - she still is!

Now perhaps because of this very abundance of food, drink and hospitality ('It wasn't the wine' murmured Mr. Snodgrass in a broken voice, 'it was the salmon'.) a short but sharp attack of gastroenteritis sent me in search of the Evelina casualty officer one evening. From the Dispensary, she produced a large stock bottle of the traditional Mist. Kaolin et Morph. and administered a single and subsequently effective dose. However, feeling somewhat sorry for myself I decided that an early night was indicated and sought the seclusion of All Hallows Vicarage. Here I let myself in, carefully locking the door behind me and climbed the stairs to my room on the first floor. Minutes later I made the trip to the bathroom along the L-shaped landing before turning in for the night. The street lights outside provided a faint but adequate illumination, so I didn't bother to switch on the electric light on the landing itself.

'...she produced a large stock bottle of the traditional Mist. Kaolin et Morph. and administered a single and subsequently effective dose.'

Rather to my surprise, as I eventually left the bathroom, I heard the front door being unlocked! A flickering light, which was accompanied by a curious hissing,appeared in the hall and began to mount the stair. I stayed unseen just short of the top of the staircase, while the figure of a man carrying a pressurised paraffin lamp (hence the hissing noise) passed close in front of me and proceeded along the landing into the room next to mine.

One of the few luxuries in an otherwise rather spartan existence was an early morning cup of tea brought by the cleaning

He shut the door behind him, whereupon I took the opportunity of going very quietly to my own room where I too shut and locked the door. For the next quarter of an hour I could hear him moving about as if searching for something, and then he went away downstairs again. The front door shut with a bang. After a few minutes I too went cautiously downstairs to check that the door was locked. Finding that it was, and that once again I apparently had the place to myself, I went to bed and slept soundly.

One of the few luxuries in an otherwise rather spartan existence was an early morning cup of tea brought by the cleaning lady. When she duly appeared next

morning I enquired about the man who had been in the previous evening. She gave me a sympathetic look, then 'You and me are the only two people with a key to this place', she replied. Nevertheless she did look into the other room, but nothing was disturbed or missing. Later that morning I made enquiry at the hospital only to receive s similar reply.

'So who was the mysterious visitor?...'

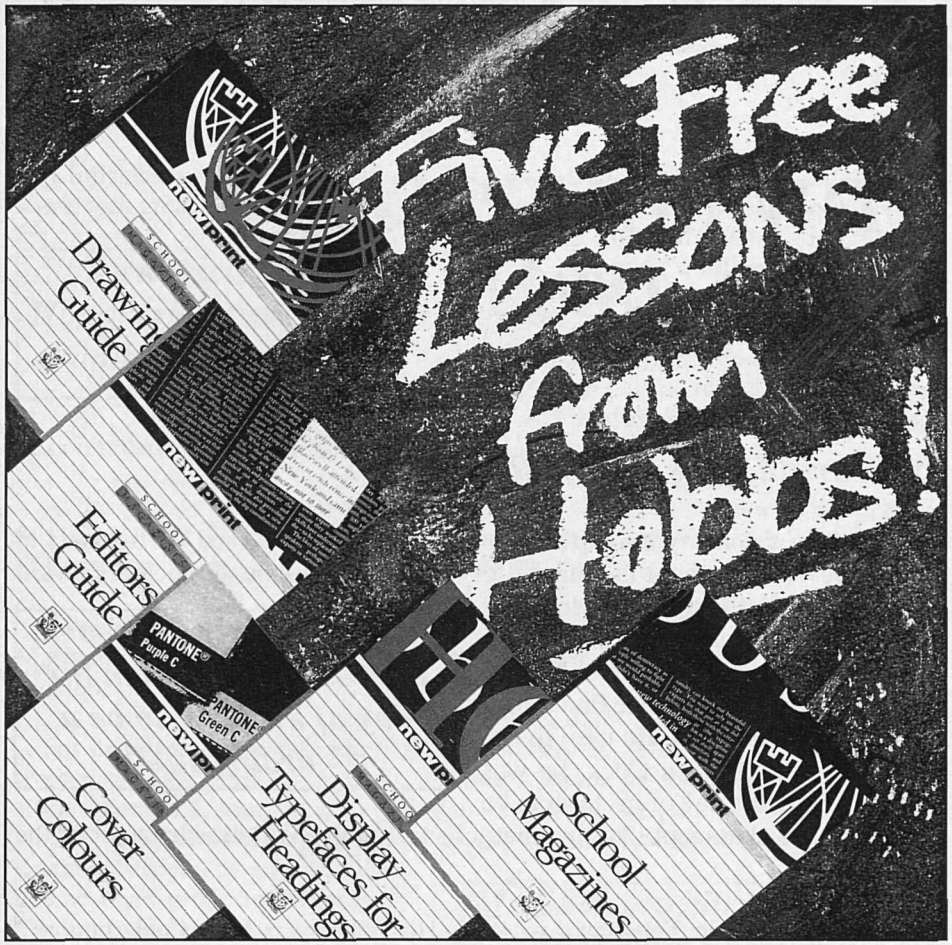
Apart from this odd incident the take-in was unremarkable, but some weeks later I was to learn that another student had a curious experience when he received his wake-up call an hour earlier than usual from a strange man and then had the normal one from the cleaner at the usual time!

So who was the mysterious visitor? Someone with a duplicate key, or a figment of the imagination? The result of gastro-intestinal toxins, or the remedy? (Mist. Kaolin and Morph. contained a significant amount of morphine and at that time stock bottles had no use-by date on them). Or perhaps some long-lost vicar searching for a missing sermon? Alas, I shall never know, unless of course there is someone out there who knows the full history of All Hallows Vicarage; but probably like the poor old Evelina it is now no more. However there is one thing of which I am quite certain - it wasn't Santa Claus!

Hugh M Baird

Acknowledgments

I wish to acknowledge the very considerable help and information obtained from HE Priestley's fascinating account of The Evelina on which I have drawn considerably. I would also like to express my gratitude to the Staff of the Wills Library for their help in the preparation of this article.



When you produce a school magazine you need good stories, witty headlines, sharp layouts and great pictures. You also need all the help you can get to achieve the best results.

HOBBS
newprint

programme that works! School magazines are produced the *Newprint* way all over the country.

You need *Newprint* from Hobbs. A service designed to help you bring your ideas into successful print. Five step by step guides take you through the production process from story selection to publication – and it's a

Newprint is economical, carefully planned, but above all it's exciting. Imagine – colour covers, action photographs and no limit to drawings and images – all within a pre-defined budget.

Send for your *Newprint* package or call Hobbs today.

You could learn a few things from the School magazine masters!

HOBBS THE PRINTERS LIMITED, BRUNEL ROAD, TOTTON, HAMPSHIRE SO40 3YS

TEL: 01703 664800

EDWARD COCK (1805 - 1892)

Guy's Characters
by Harold Ellis CBE FRCS

Among the many colourful characters who have served on the staff at Guy's throughout its long history must certainly be numbered Edward Cock. Although a general surgeon, he was particularly interested in the genitourinary tract and he can therefore be regarded as the first urologist at Guy's Hospital. He used to say that, with a name like Cock, he was doomed from the day of his birth to be a urologist; a statement like that that tells us much about the character of the man!.

'...with a name like Cock, he was doomed from the day of his birth to be a urologist.'

Cock was born in Tottenham in 1805. His father was John Cock Junior, a Lloyd's underwriter. The family was connected to Henry Cline, a surgeon at St. Thomas's Hospital and it was through Cline that Astley Cooper met his future wife. Lady Cooper was the daughter of Edward's grandfather, John Cock Senior and thus Astley Cooper became Edward's uncle. So in 1821 young Edward was apprenticed to his uncle and began his studies at St. Thomas's Hospital. When the separation of the medical teaching at Guy's and St. Thomas's took place in 1825, Cock followed his uncle to Guy's where he was appointed to demonstrator in anatomy before he

'When the separation of the medical teaching at Guy's and St. Thomas's took place in 1825, Cock followed his uncle to Guy's...'

had finished his apprenticeship. He qualified MRCS in 1828 and continued to work with great energy in the dissecting room for a further ten years until elected Assistant Surgeon to Guy's Hospital in 1838, becoming a full surgeon in 1849 and continuing as such until 1871 when he retired as consulting surgeon. When the Pupils Physical Society was established at Guy's in 1836, Cock was elected the first Honorary President and he continued this post for the next 40 years.

'he was elected the first Honorary President of the Pupils Physical Society'

At the Royal College of Surgeons of England, Cock become one of the first 27 fellows in 1843. He went on to serve on it's council, was a member of the Court of Examiners and served as President in 1869.

Edward remained a bachelor until the age of 62 when, in 1870, he married a Marianna Nunn. They had no children but lived happily together until her death in 1886.

For nearly all his active life Cock was intimately associated with Guy's and lived just a few yards away in St. Thomas's Street. Of his doings innumerable stories were told, some at least of which are true. At the back of his house he had a little garden; an old gardener came as an out-patient to the hospital whose face was so destroyed by a rodent ulcer that no-one would employ him. Mr Cock provided him with an artificial nose kept in place by a pair of spectacles and engaged him to look after his garden. It is said that a constable on night duty once found Cock sitting with his back to the wall facing his own house. The policeman, who like all members of the force stationed near the hospital were on friendly terms with him said 'what are you doing here, sir?' to which Cock replied ' waiting for Mr Cock's house to come round'. In spite of his unfashionable address, he had a large practice and, as well as his private patients, he was well known to the thieves and rogues of the slums of Southwark who frequented the hospital. In dress he was quite indifferent to conventional ideas. In summer he usually wore a large shepherd's plaid for

'Mr Cock provided him with an artificial nose kept in place by a pair of spectacles and engaged him to look after his garden'

trousers, a buff waistcoat with onyx buttons and a silk-lined jacket with a blue spot necktie and white hat. In winter, the white hat was changed for a black one. A massive gold chain and an ivory-handled cane completed the picture. 'Old Cock' or 'Teddy Cock', as he was called by many generations of students, was a man rather below average height and a slight stoop which made him seem prematurely old. His grand head and face, and a pleasant expression atoned for a somewhat diminutive frame. His complexion was pink and delicate, his blue eyes were protected by gold-rimmed spectacles and he had a firm acquiline nose with a most attractive smile. He was cultured and had a infinite sense of humour.

'A massive gold chain and an ivory-handled cane completed the picture of 'Old Cock' or 'Teddy Cock', as he was called'

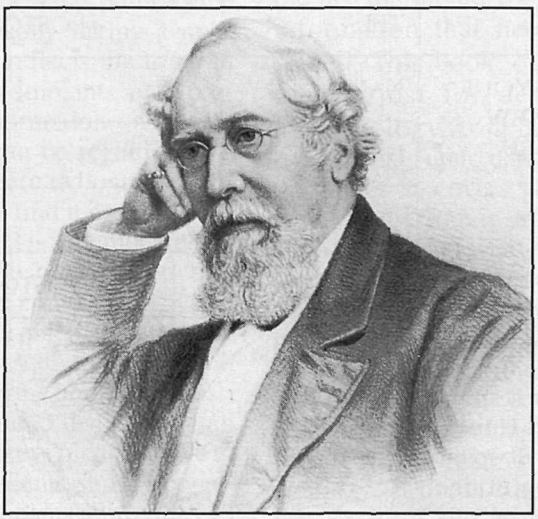
In surgery, his name is connected with the treatment of extreme cases of impermeable stricture of the urethra, impossible to treat by any other means available at that time; a condition virtually unseen in the Western World today. His operation consisted of stabbing through the perineum with a sharp knife guided by the forefinger in the rectum to localise the apex of the prostate. This would enable the dilated bulbous portion of the urethra proximal to the stricture to be opened and a self-retaining catheter to be passed into the bladder. This replaced the terrible procedure which surgeons would inflict on such patients by forcing a metal bougie along the urethra and create a false passage through the prostate into the bladder by brute force, of course, in those days without anaesthetic. The description of Cock's operation was published in the Guy's Reports in 1866. It was also due to his teaching that gradual dilatation with flexible bougies replaced forcible dilatation with rigid instruments in the treatment of permeable strictures. He was the first in the country to perform a pharyngotomy with success and thus removed a dental plate firmly impacted in the gullet. He was also one of the first surgeons to trephine for an extradural haemorrhage, this operation dating back to 1842. Cock's name is also perpetuated eponymously as 'Cock's peculiar tumour'. The patient was an elderly woman who

'In surgery, his name is connected with the treatment of extreme cases of impermeable stricture of the urethra.'

came to out-patients at Guy's wearing a curious hat rather like a fez and complaining of a lump on her scalp which had been present for 47 years and which was now bleeding from time to time. On removal of the turban, an enormous vascular ulcerated tumour was seen. However when this was removed (with torrential haemorrhage) it proved to be an enormous sebaceous cyst - it was 'a peculiar tumour' because it looked malignant and yet was entirely benign. This case, like so many other reports by Cock, was again published in Guy's reports of 1853.

'Cock's name is also perpetuated eponymously as 'Cock's peculiar tumour'

As an old man, Cock went to live in Kingston and died in 1892. Perhaps appropriately, the exact date of his death was April 1st.



Edward Cock (1805-1892)

Changing Your Address?

Please give us SIX WEEKS' NOTICE of your move. This will help us to make sure your *Gazettes* continue to reach you.

PRINT YOUR NAME AND **OLD** ADDRESS	NAME	
	OLD ADDRESS	
	TEL.	POSTCODE
THEN PRINT YOUR NAME AND **NEW** ADDRESS HERE	NAME	
	NEW ADDRESS	
	TEL.	POSTCODE

Now cut out this coupon and send to:

Guy's Hospital Gazette
Boland House
Guy's Hospital
London Bridge
London SE1 9RT

Essentials of Dental Radiography and Radiology

Second Edition Eric Whaites
Published by Churchill Livingstone
ISBN 044353499

The format of this book is very similar to the first edition in that the information is well presented and clearly laid out.

The author has made sound effort in ensuring the material is presented as simply as possible. All aspects of dental radiology and radiography are covered from the legal stand point to the nitty gritty of actually taking x-rays. The latest edition reflects the trend in dentistry towards implants and provides valuable information on assessment. The book can be regarded as a tool by which to learn radiography and many students will find it invaluable in that much of the text is accompanied by easy to follow illustrations and diagrams. Given the complexity of the subject and the problems that many students encounter with the interpretation of radiographs the book provides a 'step by step' guide to deciphering all 'black, white and grey' pictures have to tell. All dental students should be advised to buy this book as it provides all the material required of an undergraduate without overloading them with unnecessary information and at a very reasonable price. Overall, an excellent textbook, definitely worth buying, but if you are strapped for cash than consider it a wise investment to save for!

Nabeela Ahmed

Essential Microbiology for Dentistry

L P Smaranayake
Churchill Livingstone
ISBN 0443049890

Microbiology is one of those funny subjects where I'm sure many people are dismayed by the volume of information that needs to be presented. This book, one of a few intended just for dentists, covers microbiology from basics.

It presents up to date information on the topics it covers, so at least you could study from it safe in the knowledge that most of what's in it is true. All the major oral diseases are covered and all aspects of microbiology that might have a dental implication are mentioned. The nicest thing about this book are though, that as a dentist if you look something up in this book you know that it's valid and of importance to dentistry. It doesn't however cut corners on what you need to know,so as always, there are several chapters which are covered as standard in most textbooks. If you abhor microbiology then do not despair as this book also

provides an introduction to immunology and deals with common infections which affect the various body systems. Throughout it is illustrated with lots of little pictures, often to remind you of the links of the subjects to dentistry. A good book. Worth buying if you like the subject. It contains a lot more information than you'd find in general microbiology textbooks so can be used at any stage throughout the dental course for related subject areas.

Nabeela Ahmed

Barbed Wired Doctor

Brigadier Anthony Crook MC
Published by Pentland Press
ISBN 1 85821 383 5 Price 14.50

There are few accounts of the experiences of our prisoners of war incarcerated by Hitler's armies during the Second World War, particularly from the perspective of a medical officer confronted with the dilemma of escape or duty to his wounded compatriots. Captain Crook was the medical officer of the 2nd Battalion, The Royal Warwickshire Regiment serving in 1939-40 on the Belgian frontier and latterly on the Maginot Line.

Encircled by the SS. Liebstandarte Regiment, commanded by the infamous Sepp Dietrich, the Regiment fought to the last man. Crook was subsequently awarded the MC for his gallantry. He, together with the wounded, after a vain attempt to break out was captured and he spent the next five years moving from one camp to another. Resilient, courageous and ingenious he became a thorn in the side of his captors. Following his third attempted escape he was transported to Poland, where he was finally liberated by the advancing Russian Army. After an eventful journey he ended up in Odessa on the Black Sea.

"Barbed Wire Doctor" is a story of an indefatigable spirit set against the odds, told with a modesty and humour which belies a vital contribution to the morale and fortitude of his fellow prisoners and especially his patients. A moving and remarkable book of tenacity and bravery.

The Author was Brigadier Crook son of Dr Arthur Crook of Eastbourne followed his father to Guy's Hospital, before being commissioned into the RAMC just prior to the War. He served as Regimental Medical Officer to the 2nd Battalion The Royal Warwicks and spent five years as a POW. After the war he served in India, West Africa, Malaya and Europe before retiring in 1973. He now lives in Bridport, Dorset.

Mind your Back!

The dangers of working as a nurse have always been legendary. In the past these dangers were anticipated as one of the hazards of the job. Now Health and Safety Officers are employed to ensure that all such dangers to staff and patients are kept to a minimum. Sarah Cauchi, a qualified nurse, has recently joined the Trust in this capacity. It is very costly, both in terms of time lost by Trust employees and possible damage recompense awarded if a case is brought for negligence. Of the dangers, infection and injury, feature prominently. All staff are screened and protected against infection wherever possible. Universal precautions must be adopted as an essential for prevention. Injury that results in back pain and problems is an area where a great deal has been done, although not all staff and employers take note of all precautions necessary and available. Many nurses ignore safety regulations because they think they make the job harder or more complicated. We all look for the easy way to work. But often, a little thought would indicate that by taking initial trouble, the job may be made easier, and not harder. A former Guy's nurse has made a study of the psychosocial implications of back injury at work. This was based on work funded through the Royal College of Nursing (RCN) via questionnaires sent to its Work Injured Nurses' Group (WING). In this study Mandy Mitchelmore concluded that the majority of accidents occurred to nurses working in elderly care and medical ward areas. Mandy found that the majority of these back injuries could have been prevented. I suppose the definition of most accidents could include this rider, except where forces of nature or deliberate intent to injure intervene. Mandy cites various publications, emanating from the RCN, which involve nurses becoming more aware of safer handling. Many nurses have suffered back pain and back injury over many years.It is only relatively recently that they have fought for their rights in obtaining proper damages, proper training and adequate lifting/handling equipment. There are a host of figures detailing the number of nurses who have suffered a back injury, but very little work on the effect these injuries have had on the lives of individual nurses. A common consequence was long periods off sick, subsequent medical retirement, and/or unemployment. Nurses are often their own worst enemies in seeking effective action. Many just get on with their job, and thus aggravate the initial injury to their back. They are often given little help by their employer, and even professional organisations and unions are far from helpful in some cases. Those junior management positions do not always realise the dangers they are placing themselves in. By not instructing staff

correctly in the safe handling, and not always reminding staff of its availability, such staff are building up problems for the future, and the possibility of damages being claimed. Pain causes a lot of lost time in nurses' working hours. But many nurses do not carry on. They are either devoted to the task of caring for their patients, or worried about the loss of their livelihood, or maybe both. Time off work means loss of income in certain cases, loss of pensions rights, but more significantly to some, loss of promotion chances. Mandy found that lifting patients that are too heavy accounts for the biggest number of back injuries. But hazards that cause accidents, which can be easily removed, are also a considerable source. I'm sure we have all seen objects blocking corridors or doorways which can cause falls and back injury. Regarding a colleague who has an injury as a nuisance has happened, and offering inappropriate alternatives, does not produce a happy outcome. So we wish Sarah Cauchi the best of luck in making this problem a diminishing one.

Denis Cobell

Guy's Hospital MEMORABILIA

Unique items available only from the Gazette

Hand painted Guy's crests mounted on a selection of woods. These make ideal gifts for any Guy's man or woman. Just what you need to decorate your surgery or study!

Price £25 each + £1 p&p

To: The Manager
Guy's Hospital Gazette
Boland House
St Thomas' Street
London SE1 9RT

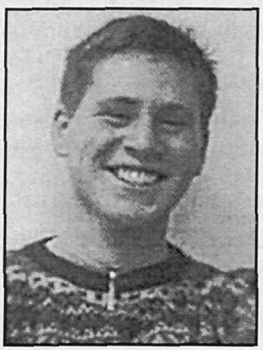
I enclose a cheque/PO for £ .....
NAME: .....
ADDRESS: .....
.....
Tel: .....

Please make cheques payable to Guy's Hospital Gazette

Office hours: Monday to Friday 1-5 pm. Personal callers welcome.

Toby L Thomas

Toby was a second year medical student at UMDS. He was tragically struck down by a lorry and killed while riding his bike in Kennington, on 24 November 1996.



Words are truly insufficient to describe the kind, funny, and determined person Toby was. Not only is his loss devastating for his family, all of his friends, and the Medical School, but his loss is a blow to the medical profession as a whole. I have no doubt he would have made a great doctor. The commitment and enthusiasm he showed for medicine was unrivalled. I had the pleasure of working with him closely, as a member of the same tutorial group. My fondest memories of him are in the dissecting room at Guy's. His diligence, and detemination shined through in his work, while his inimitable brand of humour made him a much liked and respected member of the year. We will all miss him dearly, and hope he rests in peace.

Jason O'Neale Roach

Clare Patricia Vaughan

Clare Vaughan died on 6th July 1996 after a long and courageous battle against breast cancer. She missed her fortieth birthday by two weeks.

We celebrated her life at a huge and wonderful gathering in her garden 2 months later with food she would have been proud of, music by Bjork, a hymn from our childhood and fantastic fireworks. Her children Sam 13, Jon 11 and Maddie 5 joined in with great bravery and we could feel Clare's spirit living on.

She went to Medical school at Guy's in 1974 and after 2nd MB she obtained a degree in Psychology. She went on to win prizes in Psychological Medicine, the Dennis Deuchar Memorial Award and the Richard Ellis Prize in Paediatrics. She married her fellow student Peter Openshaw in 1979 and qualified the following year. Clare undertook house jobs at Lewisham and Guy's and it was during those particularly busy and demanding years that her interest in Medical Education developed. Years before her peers, she felt that teaching medical skills at all levels was an area ripe for development. She loved the close, almost family, relationship of the firm structure which thrived on the hours that juniors dedicated to their work. Towards the end of her life however she worried that this had become utterly disrupted by the reduction in

junior doctor hours to such a point that there was no sense of role for young housemen. Clare trained for General Practice, realising that this career would perhaps accommodate the demands of motherhood and worked for 5 years in a busy practice in a deprived inner city area. Her skills helped to develope the practice from a traditional two hundred year old surgery into a thriving Primary Health Care Team. She was a brilliant G.P., with acute insight into people's stories and an ability to pursue problems where others might have lost interest.

She also trained as a Forensic Medical Examiner and joined in the rota to visit the local Police Station at all hours, fascinated by all the different experiences that it gave her. Clare's career was interrupted by a difficult third pregnancy, a tragic car crash and, just as plans were being finalised to go with her family to the U.S.A. for 2 years, she found out that she had breast cancer. From the outset Clare feared that she "couldn't conquer this one". She completed all her treatments with great courage and then gradually rebuilt her career, this time expanding her interests in medical Teaching. She became Joint Head of teaching and Lecturer in General Practice at Kings' and became a Postgraduate tutor in the King's area. Clare became a Course Organiser on the G.P. Vocational Training Scheme at U.M.D.S. and held the Chair of the South London Organisation of Vocational Trainees.

Clare's teaching innovations highlighted "career choices" and "all the things they never told you about Clinical Medicine" directed at 4th year students and "are you ready" for final year students. She became involved in the development of more user friendly patterns of health care services and the interaction between primary and secondary services at King's Healthcare.

As a mother she never failed to keep in touch with the expanding horizons of her children. She would have been an excellent mother of teenager children, tolerant as she was of what was new in life. Her sister Anna describes Clare as living life at 150 m.p.h., far too fast for Anna to keep up with. In reality this was perhaps a reflection of Clare's limited time with us all. Somehow Clare found time for a plethora of hobbies; she was a creative potter, a gifted seamstress, a collector of art deco, a happy, reader an enthusiastic gardener. With Pete's help she created a beautiful home for her family and she is greatly missed.

Helen Cotton.

Gwenllian Barnard

Gwenllian Barnard (nee Thomas) died on 4th October 1996 in Stroud near Petersfield. She was born on 15th July 1901 in South Wales, the daughter of a clergyman.

Sister Barnard ('Tommy') started her nursing career at the East London Children's Hospital at Shadwell in 1920, where she trained for her SCN. In 1924 she moved to Guy's as a student nurse, under the matronship of Miss Hogg, but after her staff year she returned to Shadwell as night sister in 1928. She returned to Guy's in 1930 as sister in charge of the old childrens ward, on the site on which Nuffield House now stands, to work with the celebrated paediatrician, Dr Hector Cameron, author of 'Mr Guy's Hospital'. She was appointed sister in charge of the Front Surgery in 1932 by Emily McManus, then Matron. Here she was to have the daunting experience of running a major casualty department in central London close to the docks and the East End for the duration of the blitz and the Battle of Britain. She vividly related the first raid on London on 6 September 1940; the bombing of Hunt's House on 13 September 1940, and the flattening of the old Superintendent's House on 18 May 1941. Some of her out patient officers were to become illustrious Guy's names, including Atkins, Simpson, Mann, Wass, Salmon and Clarkson. Following her marriage to George Edward Barnard, a Guy's man, she left Guy's in 1942, but returned yet again in 1953 to work in matron's office, and the following year took over the running of the night nurses' home at Bramham Gardens in Earls Court. She finally retired from Guy's in 1962.

For the last few years she has lived in Hampshire near to her son David, a Guy's man, who is consultant in the maxillofacial unit, in Portsmouth. Gwen has always remained a close member of the Guy's family, and until recent years, she has rarely missed the annual Nurses League reunion.

David Barnard

Kenneth Breakspear

Breakspear, Edgar Kenneth, LDS DOrth RCS, who qualified in 1938, died on 7th November 1996 at the age of 81.

He was in orthodontic practice in Coventry and also undertook local authority work in Coventry and Birmingham. Over many years he kept in close contact with affairs at Guy's through staff and colleagues and was an enthusiastic 'Guy's man'. From student days Kenneth had been interested in orthodontics and dentistry for children. This interest matured as he regularly took part in meetings of the Bristish Society for the Study of Orthodontics (BSSO) which entailed travelling to London - not always easy for in

a man in practice then. With the support of a loving family he cultivated a wide range of enthusiasms which included walking, photography, both still and cine, and very importantly in later years his compilation of historical records of his life and times. He was also very active as a viewer and reviewer of films in which his father had stimulated his interest at the age of seven. This experience of almost 75 years ranged from Chaplin and the French and Russian schools to Guiness and Hitchcock and International Festivals. Regretfully Kenneth had poor health aggravated by being mugged quite some time ago and he died in hospital. Our sympathy goes to his widow, Betty and to their children Howard and Hilary.

Alan Campbell

Peggy Irvine

Irvine, Florence Margeret (Peggy) died peacefully in Guernsey on May 4th 1996. She was the beloved wife of Dr R E (Bobby) Irvine, mother, grandmother, great grandmother and friend to many member of the Guy's family.

She trained at Guy's 1941-1946 and was a loyal member of the Guy's nurses League for 50 years.

R Irvine

Kenneth Gray

Gray, Kenneth William, MBBChir died at home on 5th April 1996. He was educated at Ampleforth College where he was an outstanding cricketer. Although intending to become a doctor, he joined the Grenadier Guards on his 18th birthday, only to be discharged with the onset of diabetes. He managed this with great skill, allowing him to lead a full and active life.

He came to Guy's, from Cambridge, in September 1947, qualifying in 1950. He was a regular member of the Guy's cricket XI, and was in the team that won the Hospital Cup in 1951. He did various house appointments, including House Physician to Sir Rowan Boland and Neurological HP to Sir Charles Symonds, before becoming Junior Medical Registrar. Encouraged by his old headmaster, he applied to be MO at Ampleforth and enjoyed 29 years as a single-handed country GP and school doctor. He was as an active member of the Association of School MO's.

In retirement, he continued to be active as MO to RAF Catterrick. Eventually, his diabetes caught up with him and he coped with the severe complications with courage, helped by his deeply held religious convictions. We send our sympathy to his wife, Fiona, and her four children.

David Pugh

Women's Cricket

Women's Cricket Club Winners of UH Cricket Cup

On Sunday 8th September the newly formed UMDS women's cricket club celebrated winning the inaugral United Hospitals Women's Cricket Cup down at Kings Hospital athletic ground in East Dulwich.

After losing the first innings of the final against Kings we made our comeback by closely winning the second innings and going on to win the final innings by a grand 7 wickets. After Kings were all out for 67 in the final innings we made a determined effort to out do that score and achieved it with the help of our screaming supporters shouting advice to us - (to whom we are exceedingly grateful) Finally we would like to take this oppurtunity to thank our coaches and founders Mike Lewis, Anjay and Darwish for all their dedicated and patient expert training.

If anyone would like to play next year please contact Charlotte on 0171 231 3892 around March time.

The team: Charlotte Turrell, Nicola Lomax, George Hawkes, Elizabeth Walters, Funmi Amure, Lucy Nicholson, Leila El-Dars, Juliette Wolf-Barry, Julia Head, Pamela, Lorraine Tite, Anna Maw, Naomi Streeter, Annabel Somerville, Katheryn Mieckel.

The Students Sports Gazette

Sports Articles

Calling all UMDS Sports Captains. The Guy's Gazette is willing to publish any match reports or advertise fixtures for all sports teams at Guys's and St Thomas'.

If you are tired of only seeing rugby reports then feel free to write some for your own sport and put them in the internal post at Boland House or the Gazette office on the first floor of Boland House. The Gazette is an ideal way of keeping a permanent record of your clubs achievements while you are at college and informing others outside the Hospital about your successes. So whether its football, hockey, water polo or tindley winks the Gazette will be willing to publish it.

Now for some rugby reports!

Ed

Rugby

Guy's 1st XV v's Brighton
Saturday 7th Sept
Won 33-0

The season began in a promising manner with a solid win against a Brighton team who played gamely until the final whistle. For a change the Guy's XV were well prepared by the new captain Greg Ryan and the new coach Steve Farr, the Kent rugby development officer.

Guy's began strongly playing into the wind and continued pressure in a Gibbins penalty and a pushover try. Following this we relaxed slightly and allowed Brighton to come back into the game. Challacombe was unlucky not to score from a well worked penalty move thirty metres out when he took on the final defender rather than choosing to pass. A succession of poor options around the base of the scrum and dropped final passes meant that we did not increase the lead until just before half-time when O'Sulivan forced his way over at a short range lineout. After the interval Guy's played with slightly more direction with quality ball being won at the lineout from Wood and Davis. The front row also had the upper hand with seven wins against the head for Baladasan, O'Sullivan and Hostert. With the new law changes this season the blind side becomes much harder to defend and Guy's made good use of this with a slick move enabling Wood to score under the posts. Further tries from the elusive Davies at full-back and the new skipper Ryan finished off a very satisfactory win from a young and developing Guy's side.

Team: D Baladasan, F O'Sullivan, L Hostert, B Scholefield, B Challacombe, P Davis, G Ryan (capt), W Llewellyn, J Murphy, N Gibbins, G Lawton, P Gush, J Davies, P Morgan, M Rose. Subs used: B Wood, N Davies, Subs unused: R Clinton.

SJC

Guy's 1st XV v's Warlingham
Saturday 5th October 1996
Lost 22-28

Last year's match against Warlingham threw up one of those oddities so beloved of rugby football when an over-zealous referee refused to allow a Guy's substitute on the pitch even though they finished with 13 players. Both the London Society and the RFU apologised later but Guy's lost the game as a result.

On this occasion Guy's started disastrously. Warlingham took a quick kick-off to the right hand side when all forwards were lined up on the left and, virtually unopposed, got to the Guy's line. For the subsequent ruck a mistakle let Warlingham over for the first score, an unconverted try. It was good to see

the forwards take on Warlingham early on and rob them of a loose maul and drive them back but optimism that this indicated a collective wakening was unfounded. All the pressure and zest were with Warlingham and they soon went further ahead with two penalties followed by a third. At this stage Guy's were trying to play a very tight game and when they did get the ball, used back row moves to bring the ball back to the forwards. However, when they did try and move the ball wide, the Warlingham backs were up fast and put the Guy's centres under pressure. This was a definite disincentive for attempts at open rugby. Guy's did really not look co-ordinated. Throw backs from line-outs were missing the scrum half and knock ons from short penalties gave the ball to the opposition as well as various aimless kicks when under pressure. No doubt the coach will be wishing to address these aspects in the next training sessions. Just before half time, Guy's made ground into the Warlingham half and scored a penalty.

What a transformation the second half turned out to be. Guy's won this 19-7, but unfortunately did not even begin to play until 28-3 down. They swept back into the match with a series of scores and looked a totally different side. Gush scored under the posts from one move, Ryan from a short penalty move and Bevan for another. In an exciting finale, Guy's just failed to win the match. Thus, what had looked like a hiding turned into an exciting game and Warlingham were very happy to go away with the spoils. Perhaps early to bed and no extra-curricular activities on the Friday night for first team players might help; who knows?

Team:- D Baladasoran, F O'Sullivan, L Hostert, E Barrio, B Wood, G Ryan, B Challacombe, P Davis, J Spence, N Mullins, R Breeze, P Gush, G Lawton, G Bevan, M Rose.

SJC

Guy's 1st XV v Barnes
September 21st 1996
Won 13 - 7

For the first league game of the season Guy's entertained Barnes, newly promoted from Surrey 1. Guy's had lost their warm up match the previous week against Lewes but played reasonably well, though our new coach, Steve Farr, could identify many areas of improvement. Mr Farr is the RFU technical administrator for Kent and his expertise is a very welcome addition to the Guy's set up. His extensive notes after each game are very illuminating and should be enormously helpful to the club.

On a great day for rugby at HOP, sunny and with little wind, an early feature of the game was the Guy's tackling and the first ten minutes appeared between the halfway line and the Guy's 22. Guy's suffered an early setback when Nick Gibbons at fly-half, playing his debut match in the league, was injured after ten minutes and took no further part in the game. Guy's then scored on their first real attack. Indeed, their first visit into the opposition half, when Murphy stole away from the side of a loose maul and a fine bout of interpassing between Ryan, Murphy and Bevan, Greg Ryan scored in the corner.

With Pat Gush settling down at fly-half Guy's began to get a modicum more possession, but essentially by far the majority possession was with Barnes and, in spite of excellent tackling, Barnes eventually went over under the posts for a converted try to take the lead.

The second half followed much the same pattern, with perhaps three quarters of the possession going to Barnes and then thwarted by excellent tackling on the Guy's side. Having absorbed a good deal of pressure, Guy's scored a second time when Murphy again broke away on the blind side and Finnbar, showing speed more compatible with a winger than a hooker, sped away and unselfishly passed to Bevan to score. The match was extremely even and the score remained at 10-7 going into the final five minutes when Guy's scored again through a penalty from Gush, but in the last minute Barnes drove almost to the Guy's line. A series of penalties were then given to Barnes, but somehow Guy's with excellent tackling all round and particularly notable a last ditch tackle by Rose, kept the opposition out and, with some relief, Guy's scraped home 13 points to 7 in a match dominated for Guy's by defence. The back row of Ryan, Davis and Challacombe were outstanding, putting in tackle after tackle and supporting each other very impressively. Murphy sniped away at scrum half very effectively and the front row of Baladasaran, O'Sullivan and Lutz Hostert were solid and gave Guy's a good platform in spite of having a much lighter pack.

SJC

Guy's RFC 1st XV Fixtures

	December	
7th	Sutton and Epsom	Away
14th	Streatham and Croydon III	Away
22nd	Surrey Cup 3rd Round	TBA
	January	
4th	Old Walcountians (*)	Home
11th	Alton (*)	Away
18th	Bromley	Away
25th	Old Blues	Home
	February	
1st	Old Reigations	Home
8th	Old Alleynians (*)	Home
15th	Jersey (*)	Away
22nd	Cambridge LX	Away
	March	
1st	TBA	
8th	Kew Occasionals	Away
15th	Wimbledon	Away
22nd	Old Whitgiftians (*)	Home
29th	John Fisher Old Boys	Away
	April	
5th	Purley (*)	Away
12th	Streatham an Croydon II	Away
19th	Guy's Hospital Sevens	Home
27th	Past vs Present	Home

(*) Denotes Courage League Fixtures

UNITED CLUBS UNION SHOP

Boland House
Guys Hospital
London SE1 9RT
Tel: 0171 955 5000 Ext. 5947

Opening Times: Mon, Tue, Thur 12:00 - 2:00pm

TIES	
Guys Crested - polyester	£ 6.00
Guys Crested - silk	£14.50
Guys Striped - polyester	£ 6.00
Guys Striped - silk	£11.75
UMDS - polyester	£ 6.00
UMDS - silk	£14.50
GUYS TIE SLIDE	£ 7.25
GUYS TIE PIN	£ 4.00
GUYS CUFF LINKS	£ 8.50
GUYS SCARF	£11.50
GUYS / UNIVERSITY OF LONDON SCARF	£11.50
GUYS ENAMEL BLAZER BUTTONS - 2CM	£ 3.40
- 1.5CM	£ 3.25
GUYS LAPEL BADGES	£ 3.00
GUYS SWEATERS (Several colours)	£23.00
GUYS SWEATSHIRTS (All colours)	FROM £15.00
HOODED SWEATSHIRTS (Large or small crests, assorted colours)	£16.00
GUYS T-SHIRTS (All colours)	FROM £ 5.00
HONEYCOMBE T-SHIRT	£12.25
HONEYCOMBE COLLARED T-SHIRT	£14.75
POLO SHIRTS	£11.25
1/4 RUGBY SHIRTS (Navy/Bottle Green or Navy/Maroon with white collar. With Guys crest)	£15.25

POSTAGE & PACKAGING:
£1 For large items, 50p For small items.

Margaret Fendick
Shop Supervisor
February 1996

Run for Africa

The M.A.N project are searching for a doctor to join the back up team for their project Run for Africa. Two runner are leaving Alexandria in Egypt on the 15th August 1997 and are going to run to Cape Town in South Africa. An estimated duration of five and a half months, covering fourty five mile a day The run is in aide of two charities; Save the Children and Save the Rhino. The team of nine (two runners and seven support crew) will be travelling through the following countries in three four wheel drive vehicles:

Eygpt Sudan Ethiopia Kenya Tanzania Zambia Botswana South Africa

Anyone interested in infirmation should contact Emma Bourne, The Old Rectory, # Sutton Montis, Somerset, BA22 7HD UK. Tel: 01963 220068 Fax:01963 220750

Deaths

BREAKSPEAR Edgar Kenneth, LDS, DOrth, RCS Died peacefully on 7th November 1996 in hospital aged 81

REES Denis David Lloyd, Guy's 1946 MBBS MRCS LRCP DRCOG died on 27th Septmeber 1996

UMDS Clinical Science and Practice Lectures

Inaugural and Memorial Lectures

Spring Term 1997
Monday, 24th Feb 1997 5.30pm

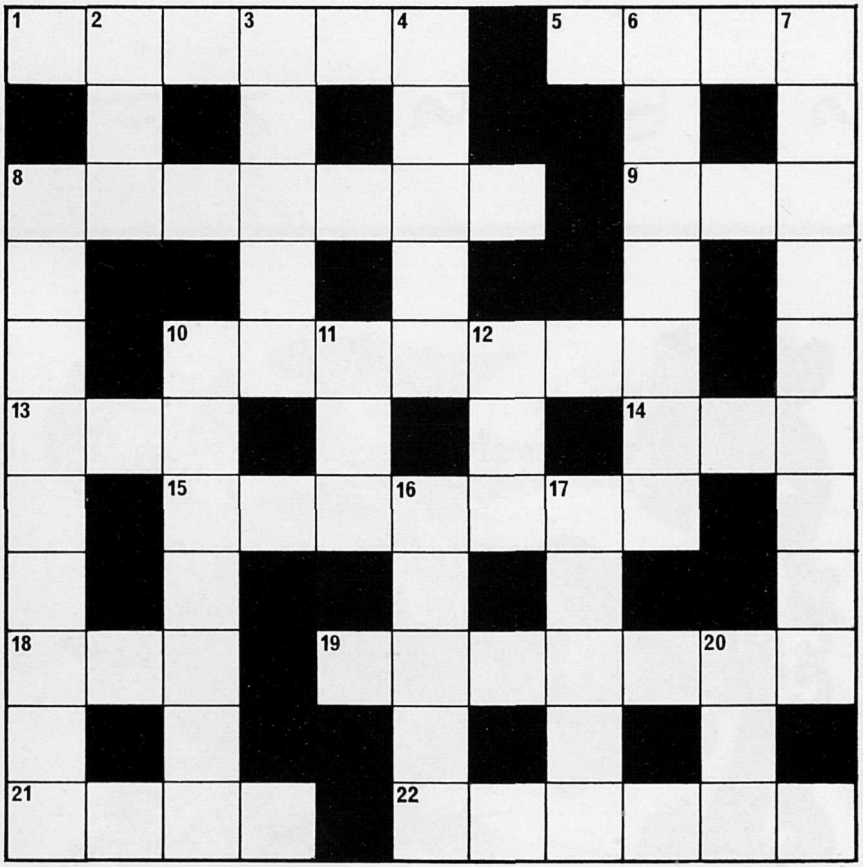
Venue:Tower Lecture Theatre, Guy's Hospital
Professor Jonathan Bates, King Alfred Professor of English Literature, University of Liverpool.
The John Keats Memorial Lecture
'Romantic Weather: Keats and the Quality of the Air'

Thursday, 6th March 1997 5.30pm

Venue: Governors' Hall, St Thomas'
Professor Hugh de Wardener CBE, Emeritus Professor of Medicine, Charing Cross & Westminster Medical School.
Evans Jones Memorial Lecture
Title to be arranged

Enquiries about these lectures to: Mary Bonner The Registry, UMDS, Guy's Hospital. 0171 9552493

THE GAZETTE CROSSWORD



ACROSS

1. A hairy, strawberry treat for dermatologists? (6)
5. The second team competed for regularity. (4)
8. Ape—one places it in mate. (7)
9. He checks run-down animals. (3)
10. One hundred raced to be top fifty at the head of the rest. (7)
13. This could come as a shock to one swimming unawares. (3)
14. Adam's beaten at chess? (3)
15. Animals accustomed to travel on comfortable linings. (7)
18. In which the guru follows the road to heaven. (3)
19. A try at seduction is not approved of. (7)
21. "He said, 'I hunt for haddocks' — Among the heather bright'." (Alice through the Looking-Glass) (4)
22. It is stimulated by light news concerning a girl. (6)

DOWN

2. First class monument initially for a target. (3)
3. Operation may avert damage to this flask. (5)
4. "O Lord Sir, when a heroine goes mad, she always goes into white —". Sheridan—The Critic, III, I. (5)
6. Evil ESR evokes feelings of disgust. (6)
7. Could be nothing or a double. (3, 3, 3)
8. True nodic tangle to bring to the notice of strangers. (9)
10. A natural disaster to avoid on cycle outside. (7)
11. A Scottish tune . . . (3)
12. . . . sounds full of anger. (3)

16 and 20. Would he ever be a geriatric paediatric? (5, 3)

17. Doctors like to do this but patients do not always enjoy it. (5)
20. See 16.

GREETINGS

CHRISTMAS